SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes.

SA 2619. Mr. NELSON of Florida (for himself and Mr. ALEXANDER) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2620. Mrs. HUTCHISON submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2621. Mrs. LINCOLN (for herself, Ms. SNOWE, Mr. NELSON of Nebraska, Mr. BAUCUS, Mr. GRASSLEY, Mr. KENNEDY, Mr. ENZI, Mr. DURBIN, Mr. CRAPO, and Mr. SMITH) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2622. Mr. CASEY (for Mr. ENZI (for himself and Ms. MIKULSKI)) proposed an amendment to the bill S. 845, to direct the Secretary of Health and Human Services to expand and intensify programs with respect to research and related activities concerning elder falls.

SA 2623. Mr. SALAZAR submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2593. Mr. LOTT (for himself, Mr. MCCONNELL, Mr. KYL, Mr. GREGG, Mr. CORNYN, Mr. BUNNING, Mr. COBURN, Mr. DEMINT, and Mrs. DOLE) proposed an amendment to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

On page 1, line 3, strike all after ''Section'' and insert the following:

1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Kids First Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION

SEC. 101. 5-YEAR REAUTHORIZATION.

(a) INCREASE IN NATIONAL ALLOTMENT.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (9), by striking ''and'' at the end;

(2) in paragraph (10), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(11) for fiscal year 2008, $7,000,000,000;

''(12) for fiscal year 2009, $7,200,000,000;

''(13) for fiscal year 2010, $7,600,000,000;

''(14) for fiscal year 2011, $8,300,000,000; and

''(15) for fiscal year 2012, $8,800,000,000.''.

(b) CONTINUATION OF ADDITIONAL ALLOTMENTS TO TERRITORIES.—Section 2104(c)(4)(B) of the Social Security Act (42 U.S.C. 1397dd(c)(4)(B)) is amended—

(1) by striking ''and'' after ''2006,''; and

(2) by inserting before the period the following: '', $56,000,000 for fiscal year 2008, $58,000,000 for fiscal year 2009, $61,000,000 for fiscal year 2010, $66,000,000 for fiscal year 2011, and $70,000,000 for fiscal year 2012''.

SEC. 102. ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA BASED ON EXPENDITURES AND NUMBERS OF LOW-INCOME CHILDREN.

(a) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by adding at the end the following new subsection:

''(i) DETERMINATION OF ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FISCAL YEARS 2008 THROUGH 2012.—

''(1) IN GENERAL.—Notwithstanding the preceding provisions of this subsection and subject to paragraph (3), the Secretary shall allot to each subsection (b) State for each of fiscal years 2008 through 2012,, the amount determined for the fiscal year that is equal to the product of—

''(A) the amount available for allotment under subsection (a) for the fiscal year, reduced by the amount of allotments made under subsection (c) (determined without regard to paragraph (4) thereof) for the fiscal year; and

''(B) the sum of the State allotment factors determined under paragraph (2) with respect to the State and weighted in accordance with subparagraph (B) of that paragraph for the fiscal year.

''(2) STATE ALLOTMENT FACTORS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the State allotment factors are the following:

''(i) The ratio of the projected expenditures for targeted low-income children under the State child health plan and pregnant women under a waiver of such plan for the fiscal year to the sum of such projected expenditures for all States for the fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(ii) The ratio of the number of low-income children who have not attained age 19 with no health insurance coverage in the State, as determined by the Secretary on the basis of the arithmetic average of the number of such children for the 3 most recent Annual Social and Economic Supplements to the Current Population Survey of the Bureau of the Census available before the beginning of the calendar year before such fiscal year begins, to the sum of the number of such children determined for all States for such fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(iii) The ratio of the projected expenditures for targeted low-income children under the State child health plan and pregnant women under a waiver of such plan for the preceding fiscal year to the sum of such projected expenditures for all States for such preceding fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(iv) The ratio of the actual expenditures for targeted low-income children under the State child health plan and pregnant women under a waiver of such plan for the second preceding fiscal year to the sum of such actual expenditures for all States for such second preceding fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(B) ASSIGNMENT OF WEIGHTS.—For each of fiscal years 2008 through 2012, the following percentage weights shall be applied to the ratios determined under subparagraph (A) for each such fiscal year:

''(i) 40 percent for the ratio determined under subparagraph (A)(i).

''(ii) 5 percent for the ratio determined under subparagraph (A)(ii).

''(iii) 50 percent for the ratio determined under subparagraph (A)(iii).

''(iv) 5 percent for the ratio determined under subparagraph (A)(iv).

''(C) DETERMINATION OF PROJECTED AND ACTUAL EXPENDITURES.—For purposes of subparagraph (A):

''(i) PROJECTED EXPENDITURES.—The projected expenditures described in clauses (i) and (iii) of such subparagraph with respect to a fiscal year shall be determined on the basis of amounts reported by States to the Secretary on the May 15th submission of Form CMS–37 and Form CMS–21B submitted not later than June 30th of the fiscal year preceding such year.

''(ii) ACTUAL EXPENDITURES.—The actual expenditures described in clause (iv) of such subparagraph with respect to a second preceding fiscal year shall be determined on the basis of amounts reported by States to the Secretary on Form CMS–64 and Form CMS–21 submitted not later than November 30 of the preceding fiscal year.''.

(b) 2-YEAR AVAILABILITY OF ALLOTMENTS; EXPENDITURES COUNTED AGAINST OLDEST ALLOTMENTS.—Section 2104(e) of the Social Security Act (42 U.S.C. 1397dd(e)) is amended to read as follows:

''(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

''(1) IN GENERAL.—Except as provided in the succeeding paragraphs of this subsection, amounts allotted to a State pursuant to this section—

''(A) for each of fiscal years 1998 through 2007, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

''(B) for each of fiscal years 2008 through 2012, shall remain available for expenditure by the State only through the end of the succeeding fiscal year for which such amounts are allotted.

''(2) ELIMINATION OF REDISTRIBUTION OF ALLOTMENTS NOT EXPENDED WITHIN 3 YEARS.—Notwithstanding subsection (f), amounts allotted to a State under this section for fiscal years beginning with fiscal year 2008 that remain unexpended as of the end of the second succeeding fiscal year shall not be redistributed to other States and shall revert to the Treasury on October 1 of the third succeeding fiscal year.

''(3) RULE FOR COUNTING EXPENDITURES AGAINST FISCAL YEAR ALLOTMENTS.—Expenditures under the State child health plan made on or after October 1, 2007, shall be counted against allotments for the earliest fiscal year for which funds are available for expenditure under this subsection.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 2104(b)(1) of the Social Security Act (42 U.S.C. 1397dd(b)(1)) is amended by striking ''subsection (d)'' and inserting ''the succeeding subsections of this section''.

(2) Section 2104(f) of such Act (42 U.S.C. 1397dd(f)) is amended by striking ''The'' and inserting ''Subject to subsection (e)(2), the''.

SEC. 103. LIMITATIONS ON MATCHING RATES FOR POPULATIONS OTHER THAN LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.

(a) LIMITATION ON PAYMENTS.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATIONS ON MATCHING RATE FOR POPULATIONS OTHER THAN TARGETED LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.—For child health assistance or health benefits coverage furnished in any fiscal year beginning with fiscal year 2008:

''(A) FMAP APPLIED TO PAYMENTS FOR COVERAGE OF CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER ENROLLED IN THE STATE CHILD HEALTH PLAN ON THE DATE OF ENACTMENT OF THE KIDS FIRST ACT AND WHOSE GROSS FAMILY INCOME IS DETERMINED TO EXCEED THE INCOME ELIGIBILITY LEVEL SPECIFIED FOR A TARGETED LOW-INCOME CHILD.—Notwithstanding subsections (b)(1)(B) and (d) of section 2110, in the case of any individual described in subsection (c) of section 105 of the Kids First Act who the State elects to continue to provide child health assistance for under the State child health plan in accordance with the requirements of such subsection, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to such assistance.

''(B) FMAP APPLIED TO PAYMENTS ONLY FOR NONPREGNANT CHILDLESS ADULTS AND PARENTS AND CARETAKER RELATIVES ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—The Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to payments for child health assistance or health benefits coverage provided under the State child health plan for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES ENROLLED UNDER A WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project on the date of enactment of the Kids First Act and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(ii) NONPREGNANT CHILDLESS ADULTS ENROLLED UNDER A WAIVER ON SUCH DATE.—A nonpregnant childless adult enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project described in section 6102(c)(3) of the Deficit Reduction Act of 2005 (42 U.S.C. 1397gg note) on the date of enactment of the Kids First Act and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(iii) NO REPLACEMENT ENROLLEES.—Nothing in clauses (i) or (ii) shall be construed as authorizing a State to provide child health assistance or health benefits coverage under a waiver described in either such clause to a nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child, or a nonpregnant childless adult, who is not enrolled under the waiver on the date of enactment of the Kids First Act.

''(C) NO FEDERAL PAYMENT FOR ANY NEW NONPREGNANT ADULT ENROLLEES OR FOR SUCH ENROLLEES WHO NO LONGER SATISFY INCOME ELIGIBILITY REQUIREMENTS.—Payment shall not be made under this section for child health assistance or other health benefits coverage provided under the State child health plan or under a waiver under section 1115 for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES UNDER A SECTION 1115 WAIVER APPROVED AFTER THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child under a waiver, experimental, pilot, or demonstration project that is approved on or after the date of enactment of the Kids First Act.

''(ii) PARENTS, CARETAKER RELATIVES, AND NONPREGNANT CHILDLESS ADULTS WHOSE FAMILY INCOME EXCEEDS THE INCOME ELIGIBILITY LEVEL SPECIFIED UNDER A SECTION 1115 WAIVER APPROVED PRIOR TO THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child whose family income exceeds the income eligibility level referred to in subparagraph (B)(i), and any nonpregnant childless adult whose family income exceeds the income eligibility level referred to in subparagraph (B)(ii).

''(iii) NONPREGNANT CHILDLESS ADULTS, PARENTS, OR CARETAKER RELATIVES NOT ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(i) on the date of enactment of the Kids First Act, and any nonpregnant childless adult who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(ii)(I) on such date.

''(D) DEFINITION OF CARETAKER RELATIVE.—In this subparagraph, the term 'caretaker relative' has the meaning given that term for purposes of carrying out section 1931.

''(E) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as implying that payments for coverage of populations for which the Federal medical assistance percentage (as so determined) is to be substituted for the enhanced FMAP under subsection (a)(1) in accordance with this paragraph are to be made from funds other than the allotments determined for a State under section 2104.''.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) of the Social Security Act (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''or subsection (c)(8)'' after ''subparagraph (B)''.

SEC. 104. PROHIBITION ON NEW SECTION 1115 WAIVERS FOR COVERAGE OF ADULTS OTHER THAN PREGNANT WOMEN.

(a) IN GENERAL.—Section 2107(f) of the Social Security Act (42 U.S.C. 1397gg(f)) is amended—

(1) by striking '', the Secretary'' and inserting ':

''(1) The Secretary''; and

(2) by adding at the end the following new paragraphs:

''(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Kids First Act that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage for any other adult other than a pregnant woman whose family income does not exceed the income eligibility level specified for a targeted low-income child in that State under a waiver or project approved as of such date.

''(3) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Kids First Act that would waive or modify the requirements of section 2105(c)(8).''.

(b) CLARIFICATION OF AUTHORITY FOR COVERAGE OF PREGNANT WOMEN.—Section 2106 of the Social Security Act (42 U.S.C. 1397ff) is amended by adding at the end the following new subsection:

''(f) NO AUTHORITY TO COVER PREGNANT WOMEN THROUGH STATE PLAN.—For purposes of this title, a State may provide assistance to a pregnant woman under the State child health plan only—

''(1) by virtue of a waiver under section 1115; or

''(2) through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations (as in effect on the date of enactment of the Kids First Act).''.

(c) ASSURANCE OF NOTICE TO AFFECTED ENROLLEES.—The Secretary of Health and Human Services shall establish procedures to ensure that States provide adequate public notice for parents, caretaker relatives, and nonpregnant childless adults whose eligibility for child health assistance or health

benefits coverage under a waiver under section 1115 of the Social Security Act will be terminated as a result of the amendments made by subsection (a), and that States otherwise adhere to regulations of the Secretary relating to procedures for terminating waivers under section 1115 of the Social Security Act.

SEC. 105. STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.

(a) ELIGIBILITY BASED ON GROSS INCOME.—

(1) IN GENERAL.—Section 2110 of the Social Security Act (42 U.S.C. 1397jj) is amended by adding at the end the following new subsection:

''(d) STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.—A State shall determine family income for purposes of determining income eligibility for child health assistance or other health benefits coverage under the State child health plan (or under a waiver of such plan under section 1115) solely on the basis of the gross income (as defined by the Secretary) of the family.''.

(2) PROHIBITION ON WAIVER OF REQUIREMENTS.—Section 2107(f) (42 U.S.C. 1397gg(f)), as amended by section 104(a), is amended by adding at the end the following new paragraph:

''(4) The Secretary may not approve a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Kids First Act that would waive or modify the requirements of section 2110(d) (relating to determining income eligibility on the basis of gross income) and regulations promulgated to carry out such requirements.''.

(b) REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate interim final regulations defining gross income for purposes of section 2110(d) of the Social Security Act, as added by subsection (a).

(c) APPLICATION TO CURRENT ENROLLEES.—The interim final regulations promulgated under subsection (b) shall not be used to determine the income eligibility of any individual enrolled in a State child health plan under title XXI of the Social Security Act on the date of enactment of this Act before the date on which such eligibility of the individual is required to be redetermined under the plan as in effect on such date. In the case of any individual enrolled in such plan on such date who, solely as a result of the application of subsection (d) of section 2110 of the Social Security Act (as added by subsection (a)) and the regulations promulgated under subsection (b), is determined to be ineligible for child health assistance under the State child health plan, a State may elect, subject to substitution of the Federal medical assistance percentage for the enhanced FMAP under section 2105(c)(8)(A) of the Social Security Act (as added by section 103(a)), to continue to provide the individual with such assistance for so long as the individual otherwise would be eligible for such assistance and the individual's family income, if determined under the income and resource standards and methodologies applicable under the State child health plan on September 30, 2007, would not exceed the income eligibility level applicable to the individual under the State child health plan.

SEC. 106. GRANTS FOR OUTREACH AND ENROLLMENT.

(a) GRANTS.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 2111. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT.

''(a) OUTREACH AND ENROLLMENT GRANTS; NATIONAL CAMPAIGN.—

''(1) IN GENERAL.—From the amounts appropriated for a fiscal year under subsection (f), subject to paragraph (2), the Secretary shall award grants to eligible entities to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

''(2) 10 PERCENT SET ASIDE FOR NATIONAL ENROLLMENT CAMPAIGN.—An amount equal to 10 percent of such amounts for the fiscal year shall be used by the Secretary for expenditures during the fiscal year to carry out a national enrollment campaign in accordance with subsection (g).

''(b) AWARD OF GRANTS.—

''(1) PRIORITY FOR AWARDING.—

''(A) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

''(i) propose to target geographic areas with high rates of—

''(I) eligible but unenrolled children, including such children who reside in rural areas; or

''(II) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

''(ii) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

''(B) 10 PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (f) for a fiscal year shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

''(2) 2-YEAR AVAILABILITY.—A grant awarded under this section for a fiscal year shall remain available for expenditure through the end of the succeeding fiscal year.

''(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

''(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

''(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

''(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

''(4) an assurance that the eligible entity shall—

''(A) conduct an assessment of the effectiveness of such activities against the performance measures;

''(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments.

''(C) in the case of an eligible entity that is not the State, provide the State with enrollment data and other information as necessary for the State to make necessary projections of eligible children and pregnant women.

''(d) SUPPLEMENT, NOT SUPPLANT.—Federal funds awarded under this section shall be used to supplement, not supplant, non-Federal funds that are otherwise available for activities funded under this section.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means any of the following:

''(A) A State with an approved child health plan under this title.

''(B) A local government.

''(C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.

''(D) A Federal health safety net organization.

''(E) A State, national, local, or community-based public or nonprofit private organization.

''(F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300x–65) relating to a grant award to non-governmental entities.

''(G) An elementary or secondary school.

''(H) A national, local, or community-based public or nonprofit private organization, including organizations that use community health workers or community-based doula programs.

''(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term 'Federal health safety net organization' means—

''(A) a Federally-qualified health center (as defined in section 1905(l)(2)(B));

''(B) a hospital defined as a disproportionate share hospital for purposes of section 1923;

''(C) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

''(D) any other entity or consortium that serves children under a federally-funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the head start and early head start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

''(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms 'Indian', 'Indian tribe', 'tribal organization', and 'urban Indian organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(4) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and health care agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with health care providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health or nutrition needs; and

''(F) by providing referral and followup services.

''(f) APPROPRIATION.—

''(1) IN GENERAL.—There is appropriated, out of any money in the Treasury not otherwise appropriated, for the purpose of awarding grants under this section—

''(A) $100,000,000 for each of fiscal years 2008 and 2009;

''(B) $75,000,000 for each of fiscal years 2010 and 2011; and

''(C) $50,000,000 for fiscal year 2012.

''(2) GRANTS IN ADDITION TO OTHER AMOUNTS PAID.—Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

''(g) NATIONAL ENROLLMENT CAMPAIGN.—From the amounts made available under subsection (a)(2) for a fiscal year, the Secretary shall develop and implement a national enrollment campaign to improve the enrollment of underserved child populations in the programs established under this title and title XIX. Such campaign may include—

''(1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

''(2) the integration of information about the programs established under this title and title XIX in public health awareness campaigns administered by the Secretary;

''(3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

''(4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

''(5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency; and

''(6) such other outreach initiatives as the Secretary determines would increase public awareness of the programs under this title and title XIX.''.

(b) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 2105(c)(2) of the Social Security Act (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following:

''(C) NONAPPLICATION TO EXPENDITURES FOR OUTREACH AND ENROLLMENT.—The limitation under subparagraph (A) shall not apply with respect to expenditures for outreach activities under section 2102(c)(1), or for enrollment activities, for children eligible for child health assistance under the State child health plan or medical assistance under the State plan under title XIX.''.

SEC. 107. IMPROVED STATE OPTION FOR OFFERING PREMIUM ASSISTANCE FOR COVERAGE THROUGH PRIVATE PLANS.

(a) IN GENERAL.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)), as amended by section 103(a) is amended by adding at the end the following:

''(9) ADDITIONAL STATE OPTION FOR OFFERING PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage in accordance with the requirements of this paragraph.

''(B) QUALIFIED EMPLOYER SPONSORED COVERAGE.—

''(i) IN GENERAL.—In this paragraph, the term 'qualified employer sponsored coverage' means a group health plan or health insurance coverage offered through an employer that is—

''(I) substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2);

''(II) made similarly available to all of the employer's employees and for which the employer makes a contribution to the premium that is not less for employees receiving a premium assistance subsidy under any option available under the State child health plan under this title or the State plan under title XIX to provide such assistance than the employer contribution provided for all other employees; and

''(III) cost-effective, as determined under clause (ii).

''(ii) COST-EFFECTIVENESS.—A group health plan or health insurance coverage offered through an employer shall be considered to be cost-effective if—

''(I) the marginal premium cost to purchase family coverage through the employer is less than the State cost of providing child health assistance through the State child health plan for all the children in the family who are targeted low-income children; or

''(II) the marginal premium cost between individual coverage and purchasing family coverage through the employer is not greater than 175 percent of the cost to the State to provide child health assistance through the State child health plan for a targeted low-income child.

''(iii) HIGH DEDUCTIBLE HEALTH PLANS INCLUDED.—The term 'qualified employer sponsored coverage' includes a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (as defined under section 223(d) of such Code).

''(C) PREMIUM ASSISTANCE SUBSIDY.—

''(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan, subject to the annual aggregate cost-sharing limit applied under section 2103(e)(3)(B).

''(ii) STATE PAYMENT OPTION.—Subject to clause (iii), a State may provide a premium assistance subsidy directly to an employer or as reimbursement to an employee for out-of-pocket expenditures.

''(iii) REQUIREMENT FOR DIRECT PAYMENT TO EMPLOYEE.—A State shall not pay a premium assistance subsidy directly to the employee, unless the State has established procedures to ensure that the targeted low-income child on whose behalf such payments are made are actually enrolled in the qualified employer sponsored coverage.

''(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

''(v) STATE OPTION TO REQUIRE ACCEPTANCE OF SUBSIDY.—A State may condition the provision of child health assistance under the State child health plan for a targeted low-income child on the receipt of a premium assistance subsidy for enrollment in qualified employer sponsored coverage if the State determines the provision of such a subsidy to be more cost-effective in accordance with subparagraph (B)(ii).

''(vi) NOT TREATED AS INCOME.—Notwithstanding any other provision of law, a premium assistance subsidy provided in accordance with this paragraph shall not be treated as income to the child or the parent of the child for whom such subsidy is provided.

''(D) NO REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND ADDITIONAL COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

''(i) IN GENERAL.—A State that elects the option to provide a premium assistance subsidy under this paragraph shall not be required to provide a targeted low-income child enrolled in qualified employer sponsored coverage with supplemental coverage for items or services that are not covered, or are only partially covered, under the qualified employer sponsored coverage or cost-sharing protection other than the protection required under section 2103(e)(3)(B).

''(ii) NOTICE OF COST-SHARING REQUIREMENTS.—A State shall provide a targeted low-income child or the parent of such a child (as appropriate) who is provided with a premium assistance subsidy in accordance with this paragraph with notice of the cost-sharing requirements and limitations imposed under the qualified employer sponsored coverage in which the child is enrolled upon the enrollment of the child in such coverage and annually thereafter.

''(iii) RECORD KEEPING REQUIREMENTS.—A State may require a parent of a targeted low-income child that is enrolled in qualified employer-sponsored coverage to bear the responsibility for keeping track of out-of-pocket expenditures incurred for cost-sharing imposed under such coverage and to notify the State when the limit on such expenditures imposed under section 2103(e)(3)(B) has been reached for a year from the effective date of enrollment for such year.

''(iv) STATE OPTION FOR REIMBURSEMENT.—A State may retroactively reimburse a parent of a targeted low-income child for out-of-pocket expenditures incurred after reaching the 5 percent cost-sharing limitation imposed under section 2103(e)(3)(B) for a year.

''(E) 6-MONTH WAITING PERIOD REQUIRED.—A State shall impose at least a 6-month waiting period from the time an individual is enrolled in private health insurance prior to the provision of a premium assistance subsidy for a targeted low-income child in accordance with this paragraph.

''(F) NON APPLICATION OF WAITING PERIOD FOR ENROLLMENT IN THE STATE MEDICAID PLAN OR THE STATE CHILD HEALTH PLAN.—A targeted low-income child provided a premium assistance subsidy in accordance with this paragraph who loses eligibility for such subsidy shall not be treated as having been enrolled in private health insurance coverage for purposes of applying any waiting period imposed under the State child health plan or the State plan under title XIX for the enrollment of the child under such plan.

''(G) ASSURANCE OF SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF ELIGIBILITY FOR PREMIUM SUBSIDY ASSISTANCE.—No payment shall be made under subsection (a) for amounts expended for the provision of premium assistance subsidies under this paragraph unless a State provides assurances to the Secretary that the State has in effect laws requiring a group health plan, a health insurance issuer offering group health insurance coverage in connection with a group health plan, and a self-funded health plan, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a child of such an employee if the child is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the employee's child becomes eligible for a premium assistance subsidy under this paragraph.

''(H) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS.—Nothing in this paragraph shall be construed as limiting

the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect on June 28, 2007.

''(I) NOTICE OF AVAILABILITY.—A State shall—

''(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer sponsored coverage;

''(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

''(iii) establish such other procedures as the State determines necessary to ensure that parents are informed of the availability of such subsidies under the State child health plan.''.

(b) APPLICATION TO MEDICAID.—Section 1906 of the Social Security Act (42 U.S.C. 1396e) is amended by inserting after subsection (c) the following:

''(d) The provisions of section 2105(c)(9) shall apply to a child who is eligible for medical assistance under the State plan in the same manner as such provisions apply to a targeted low-income child under a State child health plan under title XXI. Section 1902(a)(34) shall not apply to a child who is provided a premium assistance subsidy under the State plan in accordance with the preceding sentence.''.

SEC. 108. TREATMENT OF UNBORN CHILDREN.

(a) CODIFICATION OF CURRENT REGULATIONS.—Section 2110(c)(1) of the Social Security Act (42 U.S.C. 1397jj(c)(1)) is amended by striking the period at the end and inserting the following: '', and includes, at the option of a State, an unborn child. For purposes of the previous sentence, the term 'unborn child' means a member of the species Homo sapiens, at any stage of development, who is carried in the womb.''.

(b) CLARIFICATIONS REGARDING COVERAGE OF MOTHERS.—Section 2103 of such Act (42 U.S.C. 1397cc) is amended by adding at the end the following new subsection:

''(g) CLARIFICATIONS REGARDING AUTHORITY TO PROVIDE POSTPARTUM SERVICES AND MATERNAL HEALTH CARE.—Any State that provides child health assistance to an unborn child under the option described in section 2110(c)(1) may—

''(1) continue to provide such assistance to the mother, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends; and

''(2) in the interest of the child to be born, have flexibility in defining and providing services to benefit either the mother or unborn child consistent with the health of both.''.

SEC. 109. 50 PERCENT MATCHING RATE FOR ALL MEDICAID ADMINISTRATIVE COSTS.

Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

(1) by striking paragraph (2);

(2) by redesignating paragraph (3)(E) as paragraph (2) and re-locating and indenting it appropriately;

(3) in paragraph (2), as so redesignated, by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), and indenting them appropriately;

(4) by striking paragraphs (3) and (4);

(5) in paragraph (5), by striking ''which are attributable to the offering, arranging, and furnishing'' and inserting ''which are for the medical assistance costs of furnishing'';

(6) by striking paragraph (6);

(7) in paragraph (7), by striking ''subject to section 1919(g)(3)(B),''; and

(8) by redesignating paragraphs (5) and (7) as paragraphs (3) and (4), respectively.

SEC. 110. REDUCTION IN PAYMENTS FOR MEDICAID ADMINISTRATIVE COSTS TO PREVENT DUPLICATION OF SUCH PAYMENTS UNDER TANF.

Section 1903 of such Act (42 U.S.C. 1396b) is amended—

(1) in subsection (a)(7), by striking ''section 1919(g)(3)(B)'' and inserting ''subsection (h)'';

(2) in subsection (a)(2)(D) by inserting '', subject to subsection (g)(3)(C) of such section'' after ''as are attributable to State activities under section 1919(g)''; and

(3) by adding after subsection (g) the following new subsection:

''(h) REDUCTION IN PAYMENTS FOR ADMINISTRATIVE COSTS TO PREVENT DUPLICATION OF PAYMENTS UNDER TITLE IV.—Beginning with the calendar quarter commencing October 1, 2007, the Secretary shall reduce the amount paid to each State under subsection (a)(7) for each quarter by an amount equal to ¼ of the annualized amount determined for the Medicaid program under section 16(k)(2)(B) of the Food Stamp Act of 1977 (7 U.S.C. 2025(k)(2)(B)).''.

SEC. 111. EFFECTIVE DATE.

(a) IN GENERAL.—Subject to subsection (b), the amendments made by this title take effect on October 1, 2007.

(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State child health plan under title XXI of the Social Security Act or a waiver of such plan under section 1115 of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan or waiver to meet the additional requirements imposed by the amendments made by this title, the State child health plan or waiver shall not be regarded as failing to comply with the requirements of such title XXI solely on the basis of its failure to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this title. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

TITLE II—HEALTH INSURANCE MARKETPLACE MODERNIZATION AND AFFORDABILITY

SEC. 200. SHORT TITLE; PURPOSE.

(a) SHORT TITLE.—This title may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2007''.

(b) PURPOSES.—It is the purpose of this title to—

(1) make more affordable health insurance options available to small businesses, working families, and all Americans;

(2) assure effective State regulatory protection of the interests of health insurance consumers; and

(3) create a more efficient and affordable health insurance marketplace through collaborative development of uniform regulatory standards.

Subtitle A—Small Business Health Plans

SEC. 201. RULES GOVERNING SMALL BUSINESS HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''SEC. 801. SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means a fully insured group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership;

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation; and

''(4) does not condition membership on the basis of a minimum group size.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

''(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—A small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification

of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to a small business health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to a small business health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a plan document, by a board of trustees which pursuant to a trust agreement has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

''(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

''(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with insurers.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

''(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan—

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

''(C) an affiliated member of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

''(B) the dependents of individuals described in subparagraph (A).

''(b) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(c) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to a small business health plan if—

''(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

''(2) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate; and

''(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to a small business health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

''(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(i) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

''(ii) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)).

''(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan, and at the request of such small business health plan, from—

''(i) setting contribution rates for the small business health plan based on the claims experience of the plan so long as any variation in such rates complies with the requirements of clause (ii), except that small business health plans shall not be subject to paragraphs (1)(A) and (3) of section 2911(b) of the Public Health Service Act; or

''(ii) varying contribution rates for participating employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates, subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by subtitle B of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as

defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of part II of subtitle A of title XXIX of the Public Health Service Act (relating to lower cost plans), as added by subtitle B of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

''(c) DOMICILE AND NON-DOMICILE STATES.—

''(1) DOMICILE STATE.—Coverage shall be issued to a small business health plan in the State in which the sponsor's principal place of business is located.

''(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Health Insurance Marketplace Modernization and Affordability Act of 2007), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2007)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

''(C) LICENSURE.—Except with respect to the application of the temporary preemption provision of this paragraph, nothing in this part shall be construed to limit the requirement that insurers issuing coverage to small business health plans shall be licensed in each State in which the small business health plans operate.

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''SEC. 806. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''SEC. 807. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''A small business health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.

''SEC. 808. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor, or

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan

in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)-1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this section).

''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to inhibit the development of health savings accounts pursuant to section 223 of the Internal Revenue Code of 1986.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of a small business health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.

''(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2007) (concerning health plan rating and benefits) are met.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of a small business health plan under part 8.''.

(d) SAVINGS CLAUSE.—Section 731(c) of the Employee Retirement Income Security Act of 1974 is amended by inserting ''or part 8'' after ''this part''.

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''801. Small business health plans.
''802. Certification of small business health plans.
''803. Requirements relating to sponsors and boards of trustees.
''804. Participation and coverage requirements.
''805. Other requirements relating to plan documents, contribution rates, and benefit options.
''806. Requirements for application and related requirements.
''807. Notice requirements for voluntary termination.
''808. Definitions and rules of construction.''.

SEC. 202. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).''.

SEC. 203. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this subtitle shall take effect 12 months after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle within 6 months after the date of the enactment of this Act.

(b) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of trustees which—

(i) is elected by the participating employers, with each employer having one vote; and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

Subtitle B—Market Relief

SEC. 211. MARKET RELIEF.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 3001. GENERAL INSURANCE DEFINITIONS.

''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

''Subtitle A—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 3011. DEFINITIONS.

''(a) GENERAL DEFINITIONS.—In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted either the Model Small Group Rating Rules or, if applicable to such State, the Transitional Model Small Group Rating Rules, each in their entirety and as the exclusive laws of the State that relate to rating in the small group insurance market.

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner

or official or officials designated by the State to enforce the insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage in that State consistent with the Model Small Group Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency); and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term ' Model Small Group Rating Rules' means the rules set forth in subsection (b).

''(8) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(9) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

''(10) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''(b) DEFINITION RELATING TO MODEL SMALL GROUP RATING RULES.—The term 'Model Small Group Rating Rules' means adapted rating rules drawn from the Adopted Small Employer Health Insurance Availability Model Act of 1993 of the National Association of Insurance Commissioners consisting of the following:

''(1) PREMIUM RATES.—Premium rates for health benefit plans to which this title applies shall be subject to the following provisions relating to premiums:

''(A) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent.

''(B) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under subparagraph (A).

''(C) INCREASES FOR NEW RATING PERIODS.—The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

''(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(ii) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(D) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(E) USE OF INDUSTRY AS A CASE CHARACTERISTIC.—A small employer carrier may utilize industry as a case characteristic in establishing premium rates, so long as the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15 percent.

''(F) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(G) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(H) RESTRICTED NETWORK PROVISIONS.—For purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain a similar provision if the restriction of benefits to network providers results in substantial differences in claims costs.

''(I) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—The small employer carrier shall not use case characteristics other than age, gender, industry, geographic area, family composition, group size, and participation in wellness programs without prior approval of the applicable State authority.

''(J) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(2) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to paragraph (3), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(A) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(B) The small employer carrier has acquired a class of business from another small employer carrier.

''(C) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(3) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under paragraph (2), excluding those classes of business related to association groups under this title.

''(4) ADDITIONAL GROUPINGS.—The applicable State authority may approve the establishment of additional distinct groupings by small employer carriers upon the submission of an application to the applicable State authority and a finding by the applicable State authority that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

''(5) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(6) SUSPENSION OF THE RULES.—The applicable State authority may suspend, for a specified period, the application of paragraph (1) to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the applicable State authority either that the suspension is reasonable when considering the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

''SEC. 3012. RATING RULES.

''(a) IMPLEMENTATION OF MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the enactment of this title, the Secretary shall promulgate regulations implementing the Model Small Group Rating Rules pursuant to section 3011(b).

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the Model Small Group Rating Rules, the Secretary, in consultation with the NAIC, shall promulgate Transitional Model Small Group Rating Rules in accordance with this subsection, which shall be applicable with respect to certain nonadopting States for a period of not to exceed 5 years from the date of the promulgation of

the Model Small Group Rating Rules pursuant to subsection (a). After the expiration of such 5-year period, the transitional model small group rating rules shall expire, and the Model Small Group Rating Rules shall then apply with respect to all non-adopting States pursuant to the provisions of this part.

''(2) PREMIUM VARIATION DURING TRANSITION.—

''(A) TRANSITION STATES.—During the transition period described in paragraph (1), small group health insurance coverage offered in a non-adopting State that had in place premium rating band requirements or premium limits that varied by less than 12.5 percent from the index rate within a class of business on the date of enactment of this title, shall not be subject to the premium variation provision of section 3011(b)(1) of the Model Small Group Rating Rules and shall instead be subject to the Transitional Model Small Group Rating Rules as promulgated by the Secretary pursuant to paragraph (1).

''(B) NON-TRANSITION STATES.—During the transition period described in paragraph (1), and thereafter, small group health insurance coverage offered in a non-adopting State that had in place premium rating band requirements or premium limits that varied by more than 12.5 percent from the index rate within a class of business on the date of enactment of this title, shall not be subject to the Transitional Model Small Group Rating Rules as promulgated by the Secretary pursuant to paragraph (1), and instead shall be subject to the Model Small Group Rating Rules effective beginning with the first plan year or calendar year following the promulgation of such Rules, at the election of the eligible insurer.

''(3) TRANSITIONING OF OLD BUSINESS.—In developing the transitional model small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market, promulgate special transition standards and timelines with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the Transitional Model Small Group Rating Rules under paragraph (1), the Secretary shall provide for the application of the Transitional Model Small Group Rating Rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2007 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

''SEC. 3013. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small employer through a small business health plan, in a State.

''(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle)—

''(A) prohibit an eligible insurer from offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that offer small group health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a non-adopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 3014. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 3013.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 3015. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

''PART II—AFFORDABLE PLANS

''SEC. 3021. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the Benefit Choice Standards in their entirety and as the exclusive laws of the State that relate to benefit, service, and provider mandates in the group and individual insurance markets.

''(2) BENEFIT CHOICE STANDARDS.—The term 'Benefit Choice Standards' means the Standards issued under section 3022.

''(3) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Benefit Choice Standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the Benefit Choice Standards, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description

in the insurer's contract of the Benefit Choice Standards and that adherence to such Standards is included as a term of such contract.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(6) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

''(7) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 3022. OFFERING AFFORDABLE PLANS.

''(a) BENEFIT CHOICE OPTIONS.—

''(1) DEVELOPMENT.—Not later than 6 months after the date of enactment of this title, the Secretary shall issue, by interim final rule, Benefit Choice Standards that implement the standards provided for in this part.

''(2) BASIC OPTIONS.—The Benefit Choice Standards shall provide that a health insurance issuer in a State, may offer a coverage plan or plan in the small group market, individual market, large group market, or through a small business health plan, that does not comply with one or more mandates regarding covered benefits, services, or category of provider as may be in effect in such State with respect to such market or markets (either prior to or following the date of enactment of this title), if such issuer also offers in such market or markets an enhanced option as provided for in paragraph (3).

''(3) ENHANCED OPTION.—A health insurance issuer issuing a basic option as provided for in paragraph (2) shall also offer to purchasers (including, with respect to a small business health plan, the participating employers of such plan) an enhanced option, which shall at a minimum include such covered benefits, services, and categories of providers as are covered by a State employee coverage plan in one of the 5 most populous States as are in effect in the calendar year in which such enhanced option is offered.

''(4) PUBLICATION OF BENEFITS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary shall publish in the Federal Register such covered benefits, services, and categories of providers covered in that calendar year by the State employee coverage plans in the 5 most populous States.

''(b) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

''SEC. 3023. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as such laws—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 3022(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974

''SEC. 3024. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 3023.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 3025. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to inhibit the development of health savings accounts pursuant to section 223 of the Internal Revenue Code of 1986.''.

Subtitle C—Harmonization of Health Insurance Standards

SEC. 221. HEALTH INSURANCE STANDARDS HARMONIZATION.

Title XXIX of the Public Health Service Act (as added by section 201) is amended by adding at the end the following:

''Subtitle B—Standards Harmonization

''SEC. 3031. DEFINITIONS.

''In this subtitle:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the harmonized standards published pursuant to section 3032(d), and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such health coverage) and filed with the State pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 3032(g)(2) and an affirmation that such standards are a term of the contract.

''(3) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards certified by the Secretary under section 3032(d).

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to

enact, within 18 months of the date on which the Secretary certifies the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 3032. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

''(iv) Two representatives of insurance agents and brokers.

''(v) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

''(B) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(6) DIRECTOR AND STAFF.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Board, the chair and vice-chair of the Board may—

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

''(B) MARKET CONDUCT REVIEW.—Market conduct review standards shall be developed which provide for the following:

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

''(x) Rationale and protocols to be met before a full examination is conducted.

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the benefit, service, or provider mandate standards provided in the Benefit Choice Standards pursuant to section 3022(a).

''(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

''(E) The criteria specified in clauses (i) through (iii) of subsection (d)(2)(B).

''(d) RECOMMENDATIONS AND CERTIFICATION BY SECRETARY.—

''(1) RECOMMENDATIONS.—Not later than 18 months after the date on which all members of the Board are selected under subsection (a), the Board shall recommend to the Secretary the certification of the harmonized standards identified pursuant to subsection (c).

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall be effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

''(e) TERMINATION.—The Board shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

''(1) LISTING.—The Secretary shall maintain an up to date listing of all harmonized standards certified under this section on the Internet website of the Department of Health and Human Services.

''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards certified under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 18 months after the certification by the Secretary of harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

''SEC. 3033. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards certified under this subtitle shall supersede any and all State laws of a non-adopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the harmonized standards under this subtitle.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months after the date on harmonized standards are certified by the Secretary under this subtitle.

''SEC. 3034. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The district courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this subtitle.

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 3033.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 3035. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subtitle.

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to inhibit the development of health savings accounts pursuant to section 223 of the Internal Revenue Code of 1986.''.

TITLE III—HEALTH SAVINGS ACCOUNTS

SEC. 301. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Paragraph (2) of section 223(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(D) CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT TREATED AS QUALIFIED.—An expense shall not fail to be treated as a qualified medical expense solely because such expense was incurred before the establishment of the health savings account if such expense was incurred—

''(i) during either—

''(I) the taxable year in which the health savings account was established, or

''(II) the preceding taxable year in the case of a health savings account established after the taxable year in which such expense was incurred but before the time prescribed by law for filing the return for such taxable year (not including extensions thereof), and

''(ii) for medical care of an individual during a period that such individual was an eligible individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 302. USE OF ACCOUNT FOR INDIVIDUAL HIGH DEDUCTIBLE HEALTH PLAN PREMIUMS.

(a) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 (relating to exceptions) is amended by striking ''or'' at the end of clause (iii), by striking the period at

the end of clause (iv) and inserting ``, or'', and by adding at the end the following new clause:

``(v) a high deductible health plan, other than a group health plan (as defined in section 5000(b)(1)).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 303. EXCEPTION TO REQUIREMENT FOR EMPLOYERS TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.

(a) GREATER EMPLOYER-PROVIDED CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES TREATED AS MEETING COMPARABILITY REQUIREMENTS.—Subsection (b) of section 4980G of the Internal Revenue Code of 1986 (relating to failure of employer to make comparable health savings account contributions) is amended to read as follows:

``(b) RULES AND REQUIREMENTS.—

``(1) IN GENERAL.—Except as provided in paragraph (2), rules and requirements similar to the rules and requirements of section 4980E shall apply for purposes of this section.

``(2) TREATMENT OF EMPLOYER-PROVIDED CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES.—For purposes of this section—

``(A) IN GENERAL.—Any contribution by an employer to a health savings account of an employee who is (or the spouse or any dependent of the employee who is) a chronically ill individual in an amount which is greater than a contribution to a health savings account of a comparable participating employee who is not a chronically ill individual shall not fail to be considered a comparable contribution.

``(B) NONDISCRIMINATION REQUIREMENT.—Subparagraph (A) shall not apply unless the excess employer contributions described in subparagraph (A) are the same for all chronically ill individuals who are similarly situated.

``(C) CHRONICALLY ILL INDIVIDUAL.—For purposes of this paragraph, the term 'chronically ill individual' means any individual whose qualified medical expenses for any taxable year are more than 50 percent greater than the average qualified medical expenses of all employees of the employer for such year.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 304. CERTAIN HEALTH REIMBURSEMENT ARRANGEMENT COVERAGE DISREGARDED COVERAGE FOR HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(c)(1)(B)(iii) of the Internal Revenue Code of 1986 is amended by inserting ``or a health reimbursement arrangement'' after ``health flexible a spending arrangement''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of the enactment of this Act.

TITLE IV—STUDY

SEC. 401. STUDY ON TAX TREATMENT OF AND ACCESS TO PRIVATE HEALTH INSURANCE.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of the Treasury shall study various options and make recommendations—

(A) for reforming the tax treatment of health insurance to improve tax equity and increase access to private health care coverage; and

(B) for providing meaningful assistance to low-income individuals and families to purchase private health insurance.

(2) CONSIDERATION OF VARIOUS OPTIONS.—In carrying out the study under paragraph (1), the Secretary of the Treasury shall consider—

(A) options which rely on changes to Federal law not included in the Internal Revenue Code of 1986;

(B) options which have a goal of minimizing Federal Government outlays;

(C) options which minimize tax increases;

(D) at least one option which retains the Federal tax exclusion for employer-provided health coverage;

(E) at least one option which is budget neutral; and

(F) at least one option which maintains the current distribution of the Federal income tax burden.

(b) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary of the Treasury shall report the results of the study and the recommendations required under subsection (a) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

SA 2594. Mrs. MCCASKILL submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle E of title VI, add the following:

SEC. 673. INDEPENDENT STUDENT.

Section 480(d)(3) of the Higher Education Act of 1965 (20 U.S.C. 1087vv(d)(3)) is amended by inserting ``or is a current active member of the National Guard or Reserve forces of the United States who has completed initial military training'' after ``purposes''.

SA 2595. Mr. DEMINT submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. __. DISPOSITION OF UNUSED HEALTH BENEFITS IN CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j), respectively, and by inserting after subsection (g) the following:

``(h) CONTRIBUTIONS OF CERTAIN UNUSED HEALTH BENEFITS.—

``(1) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a cafeteria plan solely because qualified benefits under such plan include a health flexible spending arrangement under which not more than $500 of unused health benefits may be—

``(A) carried forward to the succeeding plan year of such health flexible spending arrangement, or

``(B) to the extent permitted by section 106(d), contributed by the employer to a health savings account (as defined in section 223(d)) maintained for the benefit of the employee.

``(2) HEALTH FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, the term 'health flexible spending arrangement' means a flexible spending arrangement (as defined in section 106(c)) that is a qualified benefit and only permits reimbursement for expenses for medical care (as defined in section 213(d)(1), without regard to subparagraphs (C) and (D) thereof).

``(3) UNUSED HEALTH BENEFITS.—For purposes of this subsection, with respect to an employee, the term 'unused health benefits' means the excess of—

``(A) the maximum amount of reimbursement allowable to the employee for a plan year under a health flexible spending arrangement, over

``(B) the actual amount of reimbursement for such year under such arrangement.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to taxable years beginning after December 31, 2007.

SA 2596. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, insert the following:

SEC. _____. REQUIREMENT THAT INDIVIDUALS WHO ARE ELIGIBLE FOR CHIP AND EMPLOYER-SPONSORED COVERAGE USE THE EMPLOYER-SPONSORED COVERAGE INSTEAD OF CHIP.

Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 401(a), is amended by adding at the end the following new paragraph:

``(12) REQUIREMENT REGARDING EMPLOYER-SPONSORED COVERAGE.—

``(A) IN GENERAL.—Subject to subparagraph (B), no payment may be made under this title with respect to an individual who is eligible for coverage under a group health plan or health insurance coverage offered through an employer, either as an individual or as part of family coverage.

``(B) STATE OPTION TO OFFER PREMIUM ASSISTANCE FOR HIGH-COST PLANS.—

``(i) IN GENERAL.—In the case of an individual who is otherwise eligible for coverage under this title but for the application of subparagraph (A) and who is eligible for high-cost heath insurance coverage, a State may elect to offer a premium assistance subsidy for such coverage.

``(ii) AMOUNT.—The amount of a premium assistance subsidy under this paragraph shall be determined by the State but in no case shall exceed the lesser of—

``(I) an amount equal to the value of the coverage under this title that would otherwise apply with respect to the individual but for the application of subparagraph (A); or

``(II) an amount equal to the difference between—

``(aa) the amount of the employee's share of the premium costs for the high-cost health insurance coverage (for the family or the individual, as the case may be); and

``(bb) an amount equal to 20 percent of the total premium costs for such coverage, including both the employer and employee share, (for the family or the individual, as the case may be).

``(C) HIGH-COST HEALTH INSURANCE COVERAGE.—For purposes of this paragraph, the term 'high cost health insurance coverage' means a group health plan or health insurance coverage offered through an employer in which the employee is required to pay more than 20 percent of the premium costs.

''(D) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies under this paragraph shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.''.

SA 2597. Mr. VOINOVICH (for himself and Mr. BINGAMAN) submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—HEALTH PARTNERSHIP

SEC. _01. SHORT TITLE.

This title may be cited as the ''Health Partnership Act''.

SEC. _02. STATE HEALTH REFORM PROJECTS.

(a) PURPOSE; ESTABLISHMENT OF STATE HEALTH CARE EXPANSION AND IMPROVEMENT PROGRAM.—The purposes of the programs approved under this section shall include, but not be limited to—

(1) achieving the goals of increased health coverage and access;

(2) ensuring that patients receive high-quality, appropriate health care;

(3) improving the efficiency of health care spending; and

(4) testing alternative reforms, such as building on the public or private health systems, or creating new systems, to achieve the objectives of this Act.

(b) APPLICATIONS BY STATES, LOCAL GOVERNMENTS, AND TRIBES.—

(1) ENTITIES THAT MAY APPLY.—

(A) IN GENERAL.—A State, in consultation with local governments, Indian tribes, and Indian organizations involved in the provision of health care, may apply for a State health care expansion and improvement program for the entire State (or for regions of the State) under paragraph (2).

(B) REGIONAL GROUPS.—A regional entity consisting of more than one State may apply for a multi-State health care expansion and improvement program for the entire region involved under paragraph (2).

(C) DEFINITION.—In this Act, the term ''State'' means the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico. Such term shall include a regional entity described in subparagraph (B).

(2) SUBMISSION OF APPLICATION.—In accordance with this section, each State desiring to implement a State health care expansion and improvement program may submit an application to the State Health Innovation Commission under subsection (c) (referred to in this section as the ''Commission'') for approval.

(3) LOCAL GOVERNMENT APPLICATIONS.—

(A) IN GENERAL.—Where a State declines to submit an application under this section, a unit of local government of such State, or a consortium of such units of local governments, may submit an application directly to the Commission for programs or projects under this subsection. Such an application shall be subject to the requirements of this section.

(B) OTHER APPLICATIONS.—Subject to such additional guidelines as the Secretary may prescribe, a unit of local government, Indian tribe, or Indian health organization may submit an application under this section, whether or not the State submits such an application, if such unit of local government can demonstrate unique demographic needs or a significant population size that warrants a substate program under this subsection.

(c) STATE HEALTH INNOVATION COMMISSION.—

(1) IN GENERAL.—Within 90 days after the date of the enactment of this Act, the Secretary shall establish a State Health Innovation Commission that shall—

(A) be comprised of—

(i) the Secretary;

(ii) four State governors to be appointed by the National Governors Association on a bipartisan basis;

(iii) two members of a State legislature to be appointed by the National Conference of State Legislators on a bipartisan basis;

(iv) two county officials to be appointed by the National Association of Counties on a bipartisan basis;

(v) two mayors to be appointed by the United States Conference of Mayors and the National League of Cities on a joint and bipartisan basis;

(vi) two individuals to be appointed by the Speaker of the House of Representatives;

(vii) two individuals to be appointed by the minority leader of the House of Representatives;

(viii) two individuals to be appointed by the majority leader of the Senate;

(ix) two individuals to be appointed by the minority leader of the Senate; and

(x) two individuals who are members of federally-recognized Indian tribes to be appointed on a bipartisan basis by the National Congress of American Indians;

(B) upon approval of ⅔ of the members of the Commission, provide the States with a variety of reform options for their applications, such as tax credit approaches, expansions of public programs such as medicaid and the State Children's Health Insurance Program, the creation of purchasing pooling arrangements similar to the Federal Employees Health Benefits Program, individual market purchasing options, single risk pool or single payer systems, health savings accounts, a combination of the options described in this clause, or other alternatives determined appropriate by the Commission, including options suggested by States, Indian tribes, or the public;

(C) establish, in collaboration with a qualified and independent organization such as the Institute of Medicine, minimum performance measures and goals with respect to coverage, quality, and cost of State programs, as described under subsection (d)(1);

(D) conduct a thorough review of the grant application from a State and carry on a dialogue with all State applicants concerning possible modifications and adjustments;

(E) submit the recommendations and legislative proposal described in subsection (d)(4)(B);

(F) be responsible for monitoring the status and progress achieved under program or projects granted under this section;

(G) report to the public concerning progress made by States with respect to the performance measures and goals established under this Act, the periodic progress of the State relative to its State performance measures and goals, and the State program application procedures, by region and State jurisdiction;

(H) promote information exchange between States and the Federal Government; and

(I) be responsible for making recommendations to the Secretary and the Congress, using equivalency or minimum standards, for minimizing the negative effect of State program on national employer groups, provider organizations, and insurers because of differing State requirements under the programs.

(2) PERIOD OF APPOINTMENT; REPRESENTATION REQUIREMENTS; VACANCIES.—Members shall be appointed for a term of 5 years. In appointing such members under paragraph (1)(A), the designated appointing individuals shall ensure the representation of urban and rural areas and an appropriate geographic distribution of such members. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(3) CHAIRPERSON, MEETINGS.—

(A) CHAIRPERSON.—The Commission shall select a Chairperson from among its members.

(B) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(C) MEETINGS.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting. The Commission shall meet at the call of the Chairperson.

(4) POWERS OF THE COMMISSION.—

(A) NEGOTIATIONS WITH STATES.—The Commission may conduct detailed discussions and negotiations with States submitting applications under this section, either individually or in groups, to facilitate a final set of recommendations for purposes of subsection (d)(4)(B). Such negotiations shall include consultations with Indian tribes, and be conducted in a public forum.

(B) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this subsection.

(C) MEETINGS.—In addition to other meetings the Commission may hold, the Commission shall hold an annual meeting with the participating States under this section for the purpose of having States report progress toward the purposes in subsection (a)(1) and for an exchange of information.

(D) INFORMATION.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this subsection. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission if the head of the department or agency involved determines it appropriate.

(E) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(5) PERSONNEL MATTERS.—

(A) COMPENSATION.—Each member of the Commission who is not an officer or employee of the Federal Government or of a State or local government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(B) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(C) STAFF.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and

terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(D) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(E) TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(6) FUNDING.—For the purpose of carrying out this subsection, there are authorized to be appropriated $3,000,000 for fiscal year 2007 and each fiscal year thereafter.

(d) REQUIREMENTS FOR PROGRAMS.—

(1) STATE PLAN.—A State that seeks to receive a grant under subsection (f) to operate a program under this section shall prepare and submit to the Commission, as part of the application under subsection (b), a State health care plan that shall have as its goal improvements in coverage, quality and costs. To achieve such goal, the State plan shall comply with the following:

(A) COVERAGE.—With respect to coverage, the State plan shall—

(i) provide and describe the manner in which the State will ensure that an increased number of individuals residing within the State will have expanded access to health care coverage with a specific 5-year target for reduction in the number of uninsured individuals through either private or public program expansion, or both, in accordance with the options established by the Commission;

(ii) describe the number and percentage of current uninsured individuals who will achieve coverage under the State health program;

(iii) describe the minimum benefits package that will be provided to all classes of beneficiaries under the State health program;

(iv) identify Federal, State, or local and private programs that currently provide health care services in the State and describe how such programs could be coordinated with the State health program, to the extent practicable; and

(v) provide for improvements in the availability of appropriate health care services that will increase access to care in urban, rural, and frontier areas of the State with medically underserved populations or where there is an inadequate supply of health care providers.

(B) QUALITY.—With respect to quality, the State plan shall—

(i) provide a plan to improve health care quality in the State, including increasing effectiveness, efficiency, timeliness, patient focused, equity while reducing health disparities, and medical errors; and

(ii) contain appropriate results-based quality indicators established by the Commission that will be addressed by the State as well as State-specific quality indicators.

(C) COSTS.—With respect to costs, the State plan shall—

(i) provide that the State will develop and implement systems to improve the efficiency of health care, including a specific 5-year target for reducing administrative costs (including paperwork burdens);

(ii) describe the public and private sector financing to be provided for the State health program;

(iii) estimate the amount of Federal, State, and local expenditures, as well as, the costs to business and individuals under the State health program;

(iv) describe how the State plan will ensure the financial solvency of the State health program; and

(v) provide that the State will prepare and submit to the Secretary and the Commission such reports as the Secretary or Commission may require to carry out program evaluations.

(D) HEALTH INFORMATION TECHNOLOGY.—With respect to health information technology, the State plan shall provide methodology for the appropriate use of health information technology to improve infrastructure, such as improving the availability of evidence-based medical and outcomes data to providers and patients, as well as other health information (such as electronic health records, electronic billing, and electronic prescribing).

(2) TECHNICAL ASSISTANCE.—The Secretary shall, if requested, provide technical assistance to States to assist such States in developing applications and plans under this section, including technical assistance by private sector entities if determined appropriate by the Commission.

(3) INITIAL REVIEW.—With respect to a State application for a grant under subsection (b), the Secretary and the Commission shall complete an initial review of such State application within 60 days of the receipt of such application, analyze the scope of the proposal, and determine whether additional information is needed from the State. The Commission shall advise the State within such period of the need to submit additional information.

(4) FINAL DETERMINATION.—

(A) IN GENERAL.—Not later than 90 days after completion of the initial review under paragraph (3), the Commission shall determine whether to submit a State proposal to Congress for approval.

(B) VOTING.—

(i) IN GENERAL.—The determination to submit a State proposal to Congress under subparagraph (A) shall be approved by ⅔ of the members of the Commission who are eligible to participate in such determination subject to clause (ii).

(ii) ELIGIBILITY.—A member of the Commission shall not participate in a determination under subparagraph (A) if—

(I) in the case of a member who is a Governor, such determination relates to the State of which the member is the Governor; or

(II) in the case of member not described in subclause (I), such determination relates to the geographic area of a State of which such member serves as a State or local official.

(C) SUBMISSION.—Not later than 90 days prior to October 1 of each fiscal year, the Commission shall submit to Congress a list, in the form of a legislative proposal, of the State applications that the Commission recommends for approval under this section.

(D) APPROVAL.—With respect to a fiscal year, a State proposal that has been recommended under subparagraph (B) shall be deemed to be approved, and subject to the availability of appropriations, Federal funds shall be provided to such program, unless a joint resolution has been enacted disapproving such proposal as provided for in subsection (e). Nothing in the preceding sentence shall be construed to include the approval of State proposals that involve waivers or modifications in applicable Federal law.

(5) PROGRAM OR PROJECT PERIOD.—A State program or project may be approved for a period of 5 years and may be extended for subsequent 5-year periods upon approval by the Commission and the Secretary, based upon achievement of targets, except that a shorter period may be requested by a State and granted by the Secretary.

(e) EXPEDITED CONGRESSIONAL CONSIDERATION.—

(1) INTRODUCTION AND COMMITTEE CONSIDERATION.—

(A) INTRODUCTION.—The legislative proposal submitted pursuant to subsection (d)(4)(B) shall be in the form of a joint resolution (in this subsection referred to as the ''resolution''). Such resolution shall be introduced in the House of Representatives by the Speaker, and in the Senate, by the majority leader, immediately upon receipt of the language and shall be referred to the appropriate committee of Congress. If the resolution is not introduced in accordance with the preceding sentence, the resolution may be introduced in either House of Congress by any member thereof.

(B) COMMITTEE CONSIDERATION.—A resolution introduced in the House of Representatives shall be referred to the Committee on Ways and Means of the House of Representatives. A resolution introduced in the Senate shall be referred to the Committee on Finance of the Senate. Not later than 15 calendar days after the introduction of the resolution, the committee of Congress to which the resolution was referred shall report the resolution or a committee amendment thereto. If the committee has not reported such resolution (or an identical resolution) at the end of 15 calendar days after its introduction or at the end of the first day after there has been reported to the House involved a resolution, whichever is earlier, such committee shall be deemed to be discharged from further consideration of such reform bill and such reform bill shall be placed on the appropriate calendar of the House involved.

(2) EXPEDITED PROCEDURE.—

(A) CONSIDERATION.—Not later than 5 days after the date on which a committee has been discharged from consideration of a resolution, the Speaker of the House of Representatives, or the Speaker's designee, or the majority leader of the Senate, or the leader's designee, shall move to proceed to the consideration of the committee amendment to the resolution, and if there is no such amendment, to the resolution. It shall also be in order for any member of the House of Representatives or the Senate, respectively, to move to proceed to the consideration of the resolution at any time after the conclusion of such 5-day period. All points of order against the resolution (and against consideration of the resolution) are waived. A motion to proceed to the consideration of the resolution is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the resolution, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the House of Representatives or the Senate, as the case may be, shall immediately proceed to consideration of the resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the House of Representatives or the Senate, as the case may be, until disposed of.

(B) CONSIDERATION BY OTHER HOUSE.—If, before the passage by one House of the resolution that was introduced in such House, such

House receives from the other House a resolution as passed by such other House—

(i) the resolution of the other House shall not be referred to a committee and may only be considered for final passage in the House that receives it under clause (iii);

(ii) the procedure in the House in receipt of the resolution of the other House, with respect to the resolution that was introduced in the House in receipt of the resolution of the other House, shall be the same as if no resolution had been received from the other House; and

(iii) notwithstanding clause (ii), the vote on final passage shall be on the reform bill of the other House.

Upon disposition of a resolution that is received by one House from the other House, it shall no longer be in order to consider the resolution bill that was introduced in the receiving House.

(C) CONSIDERATION IN CONFERENCE.—Immediately upon a final passage of the resolution that results in a disagreement between the two Houses of Congress with respect to the resolution, conferees shall be appointed and a conference convened. Not later than 10 days after the date on which conferees are appointed, the conferees shall file a report with the House of Representatives and the Senate resolving the differences between the Houses on the resolution. Notwithstanding any other rule of the House of Representatives or the Senate, it shall be in order to immediately consider a report of a committee of conference on the resolution filed in accordance with this subclause. Debate in the House of Representatives and the Senate on the conference report shall be limited to 10 hours, equally divided and controlled by the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees and the majority and minority leaders of the Senate or their designees. A vote on final passage of the conference report shall occur immediately at the conclusion or yielding back of all time for debate on the conference report.

(3) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(4) LIMITATION.—The amount of Federal funds provided with respect to any State proposal that is deemed approved under subsection (d)(3) shall not exceed the cost provided for such proposals within the concurrent resolution on the budget as enacted by Congress for the fiscal year involved.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide a grant to a State that has an application approved under subsection (b) to enable such State to carry out an innovative State health program in the State.

(2) AMOUNT OF GRANT.—The amount of a grant provided to a State under paragraph (1) shall be determined based upon the recommendations of the Commission, subject to the amount appropriated under subsection (k).

(3) PERFORMANCE-BASED FUNDING ALLOCATION AND PRIORITIZATION.—In awarding grants under paragraph (1), the Secretary shall—

(A) fund a diversity of approaches as provided for by the Commission in subsection (c)(1)(B);

(B) give priority to those State programs that the Commission determines have the greatest opportunity to succeed in providing expanded health insurance coverage and in providing children, youth, and other vulnerable populations with improved access to health care items and services; and

(C) link allocations to the State to the meeting of the goals and performance measures relating to health care coverage, quality, and health care costs established under this Act through the State project application process.

(4) MAINTENANCE OF EFFORT.—A State, in utilizing the proceeds of a grant received under paragraph (1), shall maintain the expenditures of the State for health care coverage purposes for the support of direct health care delivery at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received.

(5) REPORT.—At the end of the 5-year period beginning on the date on which the Secretary awards the first grant under paragraph (1), the State Health Innovation Advisory Commission established under subsection (c) shall prepare and submit to the appropriate committees of Congress, a report on the progress made by States receiving grants under paragraph (1) in meeting the goals of expanded coverage, improved quality, and cost containment through performance measures established during the 5-year period of the grant. Such report shall contain the recommendation of the Commission concerning any future action that Congress should take concerning health care reform, including whether or not to extend the program established under this subsection.

(g) MONITORING AND EVALUATION.—

(1) ANNUAL REPORTS AND PARTICIPATION BY STATES.—Each State that has received a program approval shall—

(A) submit to the Commission an annual report based on the period representing the respective State's fiscal year, detailing compliance with the requirements established by the Commission and the Secretary in the approval and in this section; and

(B) participate in the annual meeting under subsection (c)(4)(B).

(2) EVALUATIONS BY COMMISSION.—The Commission, in consultation with a qualified and independent organization such as the Institute of Medicine, shall prepare and submit to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce, the Committee on Education and Labor, and the Committee on Ways and Means of the House of Representatives annual reports that shall contain—

(A) a description of the effects of the reforms undertaken in States receiving approvals under this section;

(B) a description of the recommendations of the Commission and actions taken based on these recommendations;

(C) an evaluation of the effectiveness of such reforms in—

(i) expanding health care coverage for State residents;

(ii) improving the quality of health care provided in the States; and

(iii) reducing or containing health care costs in the States;

(D) recommendations regarding the advisability of increasing Federal financial assistance for State ongoing or future health program initiatives, including the amount and source of such assistance; and

(E) as required by the Commission or the Secretary under subsection (f)(5), a periodic, independent evaluation of the program.

(h) NONCOMPLIANCE.—

(1) CORRECTIVE ACTION PLANS.—If a State is not in compliance with a requirement of this section, the Secretary shall develop a corrective action plan for such State.

(2) TERMINATION.—For good cause and in consultation with the Commission, the Secretary may revoke any program granted under this section. Such decisions shall be subject to a petition for reconsideration and appeal pursuant to regulations established by the Secretary.

(i) RELATIONSHIP TO FEDERAL PROGRAMS.—

(1) IN GENERAL.—Nothing in this Act, or in section 1115 of the Social Security Act (42 U.S.C. 1315) shall be construed as authorizing the Secretary, the Commission, a State, or any other person or entity to alter or affect in any way the provisions of title XIX of such Act (42 U.S.C. 1396 et seq.) or the regulations implementing such title.

(2) MAINTENANCE OF EFFORT.—No payment may be made under this section if the State adopts criteria for benefits, income, and resource standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of the date of enactment of this Act.

(j) MISCELLANEOUS PROVISIONS.—

(1) APPLICATION OF CERTAIN REQUIREMENTS.—

(A) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

(i) IN GENERAL.—Subject to subparagraph (B), a State shall not permit the imposition of any preexisting condition exclusion for covered benefits under a program or project under this section.

(ii) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State program or project provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the program or project may permit the imposition of a preexisting condition exclusion but only insofar and to the extent that such exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

(B) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under the program or project shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(2) PREVENTION OF DUPLICATIVE PAYMENTS.—

(A) OTHER HEALTH PLANS.—No payment shall be made to a State under this section for expenditures for health assistance provided for an individual to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided health assistance under the plan.

(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as provided in any other provision of law, no payment shall be made to a State under this section for expenditures for health assistance provided for an individual to the extent that payment has been made or

can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) of the Social Security Act shall apply.

(3) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of the Social Security Act shall apply to States under this section in the same manner as they apply to a State under such title XIX:

(A) TITLE XI PROVISIONS.—

(i) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(ii) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

(iii) Section 1903(w) (relating to limitations on provider taxes and donations).

(iv) Section 1920A (relating to presumptive eligibility for children).

(B) TITLE xi PROVISIONS.—

(i) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

(ii) Section 1124 (relating to disclosure of ownership and related information).

(iii) Section 1126 (relating to disclosure of information about certain convicted individuals).

(iv) Section 1128A (relating to civil monetary penalties).

(v) Section 1128B(d) (relating to criminal penalties for certain additional charges).

(vi) Section 1132 (relating to periods within which claims must be filed).

(4) RELATION TO OTHER LAWS.—

(A) HIPAA.—Health benefits coverage provided under a State program or project under this section shall be treated as creditable coverage for purposes of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(B) ERISA.—Nothing in this section shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1))).

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary in each fiscal year. Amounts appropriated for a fiscal year under this subsection and not expended may be used in subsequent fiscal years to carry out this section.

SA 2598. Mr. CRAIG submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. 61__. REPEAL OF IMPOSITION OF WITHHOLDING ON CERTAIN PAYMENTS MADE TO VENDORS BY GOVERNMENT ENTITIES.

The amendment made by section 511 of the Tax Increase Prevention and Reconciliation Act of 2005 is repealed and the Internal Revenue Code of 1986 shall be applied as if such amendment had never been enacted.

SA 2599. Mr. MCCONNELL (for himself, Mr. SPECTER, and Mr. THUNE) proposed an amendment to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

At the end of the substitute, insert the following:

SEC. _____. SENSE OF THE SENATE REGARDING THE NOMINATION OF JUDGE LESLIE SOUTHWICK.

(a) FINDINGS.—The Senate makes the following findings:

(1) Judge Leslie Southwick served on the Mississippi Court of Appeals from January 1995 to December 2006, during which time he was honored by his peers for his outstanding service on the bench.

(2) The Mississippi State Bar honored Judge Southwick in 2004 with its judicial excellence award, which is awarded annually to a judge who is ''an example of judicial excellence; a leader in advancing the quality and integrity of justice; and a person of high ideals, character and integrity''.

(3) The American Bar Association has twice rated Judge Southwick well-qualified for Federal judicial service, its highest rating. As part of its evaluation, the American Bar Association considers a nominee's ''compassion,'' ''open-mindedness,'' ''freedom from bias and commitment to equal justice under law''.

(4) In 2006, the President nominated Judge Southwick to the United States District Court for the Southern District of Mississippi.

(5) Last fall, the Senate Judiciary Committee unanimously reported Judge Southwick's nomination to the full Senate for its favorable consideration.

(6) In 2007, the President nominated Judge Southwick to the United States Court of Appeals for the Fifth Circuit.

(7) The Administrative Office of the Courts has declared the Fifth Circuit vacancy to which Judge Southwick has been nominated a ''judicial emergency'' with one of the highest case filing rates in the country.

(8) Judge Southwick is the third consecutive Mississippian whom the President has nominated to address this judicial emergency.

(9) Both Senators from Mississippi strongly support Judge Southwick's nomination to the Fifth Circuit, and they strongly supported his 2 predecessor nominees to that vacancy.

(10) The only material change in Judge Southwick's qualifications between last fall when the Senate Judiciary Committee unanimously reported his district court nomination to the floor, and this year when the Committee is considering his nomination to the Fifth Circuit is that the American Bar Association has increased its rating of him from well-qualified to unanimously well-qualified.

(11) While on the State appellate bench, Judge Southwick has continued to serve his country admirably in her armed forces.

(12) In 1992, Judge Southwick sought an age waiver to join the Army Reserves, and in 2003, he volunteered to serve in a line combat unit, the 155th Separate Armor Brigade. In 2004, he took a leave of absence from the bench to serve in Iraq with the 155th Brigade Combat Team of the Mississippi National Guard. There he distinguished himself at Forward Operating Base Duke near Najaf and at Forward Operating Base Kalsu.

(b) SENSE OF SENATE.—It is the sense of the Senate that the nomination of Judge Leslie Southwick to the United States Court of Appeals for the Fifth Circuit should receive an up or down vote by the full Senate.

SA 2600. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 83, strike line 2 and insert the following:

level.

''(C) USE OF FUNDS.—Payments under this paragraph may only be used to provide health care coverage or to expand health care access or infrastructure, including, but not limited to, the provision of school-based health services, dental care, mental health services, Federally-qualified health center services, and educational debt forgiveness for health care practitioners in fields experiencing local shortages.''.

SA 2601. Mr. LEVIN (for himself, Ms. STABENOW, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 42, strike line 14 and all that follows through page 49, line 4 and insert the following:

''(a) TERMINATION OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS.—

''(1) NO NEW CHIP WAIVERS; AUTOMATIC EXTENSIONS AT STATE OPTION THROUGH FISCAL YEAR 2010.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

''(A) the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult; and

''(B) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for purposes of any fiscal year beginning on or after October 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

''(2) TERMINATION OF CHIP COVERAGE UNDER APPLICABLE EXISTING WAIVERS AT THE END OF FISCAL YEAR 2010.—

''(A) IN GENERAL.—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided to a nonpregnant childless adult under an applicable existing waiver after September 30, 2010.

''(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before October 1, 2010, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only through September 30, 2010.

''(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section

2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a nonpregnant childless adult during each of fiscal years 2008 through 2010.

''(3) OPTIONAL 1-YEAR TRANSITIONAL COVERAGE BLOCK GRANT FUNDED FROM STATE ALLOTMENT.—Subject to paragraph (4)(B), each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may elect to provide nonpregnant childless adults who were provided child health assistance or health benefits coverage under the applicable existing waiver at any time during fiscal year 2010 with such assistance or coverage during fiscal year 2011, as if the authority to provide such assistance or coverage under an applicable existing waiver was extended through that fiscal year, but subject to the following terms and conditions:

''(A) BLOCK GRANT SET ASIDE FROM STATE ALLOTMENT.—The Secretary shall set aside for the State an amount equal to the Federal share of the State's projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all nonpregnant childless adults under such waiver for fiscal year 2010 (as certified by the State and submitted to the Secretary by not later than August 31, 2010, and without regard to whether any such individual lost coverage during fiscal year 2010 and was later provided child health assistance or other health benefits coverage under the waiver in that fiscal year), increased by the annual adjustment for fiscal year 2011 determined under section 2104(i)(2)(B)(i). The Secretary may adjust the amount set aside under the preceding sentence, as necessary, on the basis of the expenditure data for fiscal year 2010 reported by States on CMS Form 64 or CMS Form 21 not later than November 30, 2010, but in no case shall the Secretary adjust such amount after December 31, 2010.

''(B) NO COVERAGE FOR NONPREGNANT CHILDLESS ADULTS WHO WERE NOT COVERED DURING FISCAL YEAR 2010.—

''(i) FMAP APPLIED TO EXPENDITURES.—The Secretary shall pay the State for each quarter of fiscal year 2011, from the amount set aside under subparagraph (A), an amount equal to the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) of expenditures in the quarter for providing child health assistance or other health benefits coverage to a nonpregnant childless adult but only if such adult was enrolled in the State program under this title during fiscal year 2010 (without regard to whether the individual lost coverage during fiscal year 2010 and was reenrolled in that fiscal year or in fiscal year 2011).

''(ii) FEDERAL PAYMENTS LIMITED TO AMOUNT OF BLOCK GRANT SET-ASIDE.—No payments shall be made to a State for expenditures described in this subparagraph after the total amount set aside under subparagraph (A) for fiscal year 2011 has been paid to the State.

''(4) STATE OPTION TO APPLY FOR MEDICAID WAIVER TO CONTINUE COVERAGE FOR NONPREGNANT CHILDLESS ADULTS.—

''(A) IN GENERAL.—Each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may submit, not later than June 30, 2011, an application to the Secretary for a waiver under section 1115 of the State plan under title XIX to provide medical assistance to a nonpregnant childless adult whose coverage is so terminated (in this subsection referred to as a ''Medicaid nonpregnant childless adults waiver'').

''(B) DEADLINE FOR APPROVAL.—The Secretary shall make a decision to approve or deny an application for a Medicaid nonpregnant childless adults waiver submitted under subparagraph (A) within 90 days of the date of the submission of the application. If no decision has been made by the Secretary as of September 30, 2011, on the application of a State for a Medicaid nonpregnant childless adults waiver that was submitted to the Secretary by June 30, 2011, the application shall be deemed approved.

''(C) STANDARD FOR BUDGET NEUTRALITY.—The budget neutrality requirement applicable with respect to expenditures for medical assistance under a Medicaid nonpregnant childless adults waiver shall—

''(i) in the case of fiscal year 2012, allow expenditures for medical assistance under title XIX for all such adults to not exceed the total amount of payments made to the State under paragraph (3)(B) for fiscal year 2011, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for calendar year 2012 over calendar year 2011, as most recently published by the Secretary; and

''(ii) in the case of any succeeding fiscal year, allow such expenditures to not exceed the amount in effect under this subparagraph for the preceding fiscal year, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the calendar year that begins during the fiscal year involved over the preceding calendar year, as most recently published by the Secretary.

''(5) SPECIAL RULES.—Notwithstanding the amendments made by the Children's Health Insurance Program Reauthorization Act of 2007:

''(A) Section 2104(e)(4)(C)(i) shall be applied by substituting '2011' for '2009'.

''(B) Section 2104(j)(1)(B)(ii)(V) shall be applied by substituting '2011' for '2009' each place it appears.

SA 2602. Mr. KERRY (for himself, Mr. BINGAMAN, Mr. SANDERS, Mr. CASEY, Mr. MENENDEZ, Mr. DURBIN, Mr. REED, Mr. BROWN, Mr. WHITEHOUSE, and Mr. BIDEN) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

At the end, add the following:

TITLE IX—IMPROVED INCENTIVES TO ENROLL UNINSURED CHILDREN AND PROTECT EXISTING COVERAGE OPTIONS

SEC. 901. IMPROVEMENTS TO THE INCENTIVE BONUSES FOR STATES.

Paragraphs (2) and (3) of section 2104(j), as added by section 105(a), are amended to read as follows:

''(2) PAYMENTS TO STATES INCREASING ENROLLMENT.—

''(A) IN GENERAL.—Subject to paragraph (3)(D), with respect to each of fiscal years 2008 through 2012, the Secretary shall make payments to States from the Incentive Pool determined under subparagraph (B).

''(B) AMOUNT.—The amount described in this subparagraph for a State for a fiscal year is equal to the sum of the following amounts:

''(i) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under paragraph (3)(A)(i)) under title XIX for the State and fiscal year multiplied by 6 percent of the projected per capita State Medicaid expenditures (as determined under paragraph (3)(B)) for the State and fiscal year under title XIX.

''(ii) SECOND TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees (as determined under paragraph (3)(A)(ii)) under title XIX for the State and fiscal year multiplied by 35 percent of the projected per capita State Medicaid expenditures (as determined under paragraph (3)(B)) for the State and fiscal year under title XIX.

''(iii) THIRD TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of third tier above baseline child enrollees (as determined under paragraph (3)(A)(iii)) under title XIX for the State and fiscal year multiplied by 90 percent of the projected per capita State Medicaid expenditures (as determined under paragraph (3)(B)) for the State and fiscal year under title XIX.

''(3) DEFINITIONS AND RULES.—For purposes of this paragraph and paragraph (2):

''(A) TIERS ABOVE BASELINE.—

''(i) FIRST TIER ABOVE BASELINE CHILD ENROLLEES.—The number of first tier above baseline child enrollees for a State for a fiscal year under title XIX is equal to the number (if any, as determined by the Secretary) by which—

''(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (C)) enrolled during the fiscal year under the State plan under title XIX; exceeds

''(II) the baseline number of enrollees described in clause (iv) for the State and fiscal year under title XIX, respectively;

but not to exceed 2 percent of the baseline number of enrollees described in subclause (II).

''(ii) SECOND TIER ABOVE BASELINE CHILD ENROLLEES.—The number of second tier above baseline child enrollees for a State for a fiscal year under title XIX is equal to the number (if any, as determined by the Secretary) by which—

''(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (C)) enrolled during the fiscal year under title XIX, as described in clause (i)(I); exceeds

''(II) the sum of the baseline number of child enrollees described in clause (iv) for the State and fiscal year under title XIX, as described in clause (i)(II), and the maximum number of first tier above baseline child enrollees for the State and fiscal year under title XIX, as determined under clause (i),

but not to exceed 7 percent of the baseline number of enrollees described in clause (i)(II), reduced by the maximum number of first tier above baseline child enrollees for the State and fiscal year under title XIX, as determined under clause (i).

''(iii) THIRD TIER ABOVE BASELINE CHILD ENROLLEES.—The number of second tier above baseline child enrollees for a State for a fiscal year under title XIX is equal to the number (if any, as determined by the Secretary) by which—

''(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (C)) enrolled during the fiscal year under title XIX, as described in clause (i)(I); exceeds

''(II) the sum of the baseline number of child enrollees described in clause (iv) for the State and fiscal year under title XIX, as described in clause (i)(II), the maximum number of first tier above baseline child enrollees for the State and fiscal year under title XIX, as determined under clause (i), and the maximum number of second tier above

baseline child enrollees for the State and fiscal year under title XIX, as determined under clause (ii).

''(iv) BASELINE NUMBER OF CHILD ENROLLEES.—The baseline number of child enrollees for a State under title XIX—

''(I) for fiscal year 2008 is equal to the monthly average unduplicated number of qualifying children enrolled in the State plan under title XIX, respectively, during fiscal year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

''(II) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under this title or title XIX, respectively, increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

''(B) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—For purposes of subparagraph (A), the projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State plan under such title, including under waivers but not including such children eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) for the fiscal year involved.

''(C) QUALIFYING CHILDREN DEFINED.—For purposes of this subsection, the term 'qualifying children' means, with respect to this title or title XIX, children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2007, for enrollment under this title or title XIX, respectively, taking into account criteria applied as of such date under this title or title XIX, respectively, pursuant to a waiver under section 1115.''.

SEC. 902. OPTIONAL COVERAGE OF OLDER CHILDREN UNDER MEDICAID AND CHIP.

(a) MEDICAID.—

(1) IN GENERAL.—Section 1902(l)(1)(D) (42 U.S.C. 1396a(l)(1)(D)) is amended by striking ''but have not attained 19 years of age'' and inserting ''but is under 19 years of age (or, at the option of a State, under such higher age, not to exceed 21 years of age, as the State may elect)''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(e)(3)(A) (42 U.S.C. 1396a(e)(3)(A)) is amended by striking ''18 years of age or younger'' and inserting ''under 19 years of age (or under such higher age as the State has elected under subsection (l)(1)(D))'' after ''18 years of age''.

(B) Section 1902(e)(12) (42 U.S.C. 1396a(e)(12)) is amended by inserting ''or such higher age as the State has elected under subsection (l)(1)(D)'' after ''19 years of age''.

(C) Section 1905(a) (42 U.S.C. 1396d(a)) is amended, in clause (i), by inserting ''or under such higher age as the State has elected under subsection (l)(1)(D)'' after ''as the State may choose''.

(D) Section 1920A(b)(1) (42 U.S.C. 1396r–1a(b)(1)) is amended by inserting ''or under such higher age as the State has elected under section 1902(l)(1)(D)'' after ''19 years of age''.

(E) Section 1928(h)(1) (42 U.S.C. 1396s(h)(1)) is amended by striking ''18 years of age or younger'' and inserting ''under 19 years of age or under such higher age as the State has elected under section 1902(l)(1)(D)''.

(F) Section 1932(a)(2)(A) (42 U.S.C. 1396u–2(a)(2)(A)) is amended by inserting ''(or under such higher age as the State has elected under section 1902(l)(1)(D))'' after ''19 years of age''.

(b) TITLE XXI.—Section 2110(c)(1) (42 U.S.C. 1397jj(c)(1)) is amended by inserting ''(or, at the option of the State, under such higher age as the State has elected under section 1902(l)(1)(D))''.

SEC. 903. MODERNIZING TRANSITIONAL MEDICAID.

(a) FOUR-YEAR EXTENSION.—

(1) IN GENERAL.—Sections 1902(e)(1)(B) and 1925(f) (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are each amended by striking ''September 30, 2003'' and inserting ''September 30, 2011''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on October 1, 2007.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a)(1), by inserting ''but subject to paragraph (5)'' after ''Notwithstanding any other provision of this title'';

(2) by adding at the end of subsection (a) the following:

''(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.''; and

(3) in subsection (b)(1), by inserting ''but subject to subsection (a)(5)'' after ''Notwithstanding any other provision of this title''.

(c) REMOVAL OF REQUIREMENT FOR PREVIOUS RECEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) (42 U.S.C. 1396r–6(a)(1)), as amended by subsection (b)(1), is further amended—

(1) by inserting ''subparagraph (B) and'' before ''paragraph (5)'';

(2) by redesignating the matter after ''REQUIREMENT.—'' as a subparagraph (A) with the heading ''IN GENERAL.—'' and with the same indentation as subparagraph (B) (as added by paragraph (3)); and

(3) by adding at the end the following:

''(B) STATE OPTION TO WAIVE REQUIREMENT FOR 3 MONTHS BEFORE RECEIPT OF MEDICAL ASSISTANCE.—A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for fewer than three months or that had applied for and was eligible for such aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.''.

(d) CMS REPORT ON ENROLLMENT AND PARTICIPATION RATES UNDER TMA.—Section 1925 (42 U.S.C. 1396r–6), as amended by this section, is further amended by adding at the end the following new subsection:

''(g) COLLECTION AND REPORTING OF PARTICIPATION INFORMATION.—

''(1) COLLECTION OF INFORMATION FROM STATES.—Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State's child health plan under title XXI. Such information shall be submitted at the same time and frequency in which other enrollment information under this title is submitted to the Secretary.

''(2) ANNUAL REPORTS TO CONGRESS.—Using the information submitted under paragraph (1), the Secretary shall submit to Congress annual reports concerning enrollment and participation rates described in such paragraph.''.

(e) EFFECTIVE DATE.—The amendments made by subsections (b) through (d) shall take effect on the date of the enactment of this Act.

SEC. 904. REPEAL OF TOP INCOME TAX RATE REDUCTION FOR TAXPAYERS WITH $1,000,000 OR MORE OF TAXABLE INCOME.

(a) IN GENERAL.—Section 1(i) of the Internal Revenue Code of 1986 (relating to rate reductions) is amended by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

''(3) EXCEPTION FOR TAXPAYERS WITH TAXABLE INCOME OF $1,000,000, OR MORE.—

''(A) IN GENERAL.—Notwithstanding paragraph (2), in the case of taxable years beginning in a calender year after 2007, the last item in the fourth column of the table under paragraph (2) shall be applied by substituting '39.6%' for '35.0%' with respect to taxable income in excess of $1,000,000 (one-half of such amount in the case of taxpayers to whom subsection (d) applies).

''(B) INFLATION ADJUSTMENT.—In the case of the dollar amount under subparagraph (A), paragraph (1)(C) shall be applied by substituting '2008' for '2003' and '2007' for '2002'.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

(c) APPLICATION OF EGTRRA SUNSET.—The amendment made by this section shall be subject to title IX of the Economic Growth and Tax Relief Reconciliation Act of 2001 to the same extent and in the same manner as the provision of such Act to which such amendment relates.

SA 2603. Mrs. HUTCHISON submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I add the following:

SEC. 112. FUNDING PRIORITY FOR STATES WITH AN EFFECTIVE INCOME ELIGIBILITY LEVEL FOR CHILDREN THAT DOES NOT EXCEED 200 PERCENT OF THE POVERTY LINE.

(a) PRIORITY FOR DETERMINATION OF FISCAL YEAR 2008 ALLOTMENTS.—Subparagraph (D) of section 2104(i)(2) (42 U.S.C. 1397dd(i)(2))), as added by section 102, is amended to read as follows:

''(D) PRIORITY AND PRORATION RULES.—If, after the application of this paragraph without regard to this subparagraph, the sum of the State allotments determined under this paragraph for fiscal year 2008 exceeds the available national allotment for fiscal year 2008, the Secretary shall—

''(i) first, provide the allotments for all subsection (b) States for which the effective income eligibility level for child health assistance for targeted low-income children under the State child health plan does not exceed 200 percent of the poverty line (and if, the sum of such allotments exceeds the available national allotment for fiscal year

2008, reduce each such allotment on a proportional basis); and

''(ii) only to the extent there are any amounts remaining available for allotment from the available national allotment for fiscal year 2008 after the application of clause (i), provide, on a proportional basis, allotments for any other subsection (b) States.''.

(b) PRIORITY FOR DETERMINATION OF FISCAL YEAR 2009 THROUGH 2012 ALLOTMENTS.—Subparagraph (A) of section 2104(i)(3) (42 U.S.C. 1397dd(i)(3)), as so added, is amended to read as follows:

''(A) IN GENERAL.—If the sum of the State allotments determined under paragraph (1)(A)(ii) for any of fiscal years 2009 through 2011 exceeds the available national allotment for the fiscal year, the Secretary shall—

''(i) first, allot to each subsection (b) State for which the effective income eligibility level for child health assistance for targeted low-income children under the State child health plan does not exceed 200 percent of the poverty line from the available national allotment for the fiscal year an amount equal to the product of—

''(I) the available national allotment for the fiscal year; and

''(II) the percentage equal to the sum of the State allotment factors for the fiscal year determined under paragraph (4) with respect to the State; and

''(ii) only to the extent there are any amounts remaining available for allotment from the available national allotment for the fiscal year after the application of clause (i), determine the allotments for any other subsection (b) States in the same manner as how allotments are determined under clause (i).''.

(c) CHIP CONTINGENCY FUND.—Section 2104(k)(3) (42 U.S.C. 1397dd(k)(3)), as added by section 108, is amended by adding at the end the following new subparagraph:

''(I) PRIORITY FOR STATES WITH AN EFFECTIVE INCOME ELIGIBILITY LEVEL FOR CHILDREN THAT DOES NOT EXCEED 200 PERCENT OF THE POVERTY LINE.—Notwithstanding subparagraph (E), the Secretary shall make monthly payments from the Fund—

''(i) first, to those States that are determined to be eligible States with respect to a month and for which the effective income eligibility level for child health assistance for targeted low-income children under the State child health plan does not exceed 200 percent of the poverty line (and, if the sum of such payments exceed the amount in the Fund, reduced on a proportional basis); and

''(ii) only to the extent that there are any amounts remaining in the Fund for a month, to any other States that are determined to be eligible States with respect to the month (and reduced, if necessary, on a proportional basis).''.

SA 2604. Mrs. HUTCHISON submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 142, strike lines 14 through 23 and insert the following:

''(J) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS OR PENDING WAIVERS FOR SUCH PROGRAMS.—Nothing in this paragraph shall be construed as—

''(i) limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect prior to the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007; or

''(ii) limiting the authority of a State to offer premium assistance under a waiver pending approval by the Secretary prior to such date of enactment that is approved on or after such date of enactment.''.

SA 2605. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill S. 1, to provide greater transparency in the legislative process; which was ordered to lie on the table; as follows:

Strike subtitle B of title V of the amendment and insert the following:

Subtitle B—Earmark, Conference, and Conflict of Interest Reform

SEC. 521. OUT OF SCOPE MATTERS IN CONFERENCE REPORTS.

(a) IN GENERAL.—A point of order may be made by any Senator against any item contained in a conference report that includes or consists of any matter not committed to the conferees by either House. The point of order may be made and disposed of separately for each item in violation of this section.

(b) DISPOSITION.—If the point of order raised against an item in a conference report under subsection (a) is sustained—

(1) the matter in such conference report shall be stricken; and

(2) when all other points of order under this section have been disposed of—

(A) the Senate shall proceed to consider the question of whether the Senate should recede from its amendment to the House bill, or its disagreement to the amendment of the House, and concur with a further amendment, which further amendment shall consist of only that portion of the conference report that has not been stricken (any modification of total amounts appropriated necessary to reflect the deletion of the matter struck from the conference report shall be made);

(B) the question shall be debatable; and

(C) no further amendment shall be in order.

(c) LIMITATION.—

(1) IN GENERAL.—In this section, the term ''matter not committed to the conferees by either House'' shall include any item which consists of a specific provision containing a specific level of funding for any specific account, specific program, specific project, or specific activity, when no such specific funding was provided for such specific account, specific program, specific project, or specific activity in the measure originally committed to the conferees by either House.

(2) RULE XXVIII.—For the purpose of rule XXVIII of the Standing Rules of the Senate, the term ''matter not committed'' shall include any item which consists of a specific provision containing a specific level of funding for any specific account, specific program, specific project, or specific activity, when no such specific funding was provided for such specific account, specific program, specific project, or specific activity in the measure originally committed to the conferees by either House.

(d) SUPERMAJORITY WAIVER AND APPEAL.—This section may be waived or suspended in the Senate only by an affirmative vote of ⅗ of the Members, duly chosen and sworn. An affirmative vote of ⅗ of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

SEC. 522. CONGRESSIONAL EARMARK REFORM.

The Standing Rules of the Senate are amended by adding at the end the following:

''RULE XLIV

''EARMARKS

''1. It shall not be in order to consider—

''(a) a bill or joint resolution reported by a committee unless the report includes a list, which shall be made available on the Internet in a searchable format to the general public for at least 48 hours before consideration of the bill or joint resolution, of congressional earmarks, limited tax benefits, and limited tariff benefits in the bill or in the report (and the name of any Member who submitted a request to the committee for each respective item included in such list) or a statement that the proposition contains no congressional earmarks, limited tax benefits, or limited tariff benefits;

''(b) a bill or joint resolution not reported by a committee unless the chairman of each committee of jurisdiction has caused a list, which shall be made available on the Internet in a searchable format to the general public for at least 48 hours before consideration of the bill or joint resolution, of congressional earmarks, limited tax benefits, and limited tariff benefits in the bill (and the name of any Member who submitted a request to the committee for each respective item included in such list) or a statement that the proposition contains no congressional earmarks, limited tax benefits, or limited tariff benefits to be printed in the Congressional Record prior to its consideration; or

''(c) a conference report to accompany a bill or joint resolution unless the joint explanatory statement prepared by the managers on the part of the House and the managers on the part of the Senate includes a list, which shall be made available on the Internet in a searchable format to the general public for at least 48 hours before consideration of the conference report, of congressional earmarks, limited tax benefits, and limited tariff benefits in the conference report or joint statement (and the name of any Member, Delegate, Resident Commissioner, or Senator who submitted a request to the House or Senate committees of jurisdiction for each respective item included in such list) or a statement that the proposition contains no congressional earmarks, limited tax benefits, or limited tariff benefits.

''2. For the purpose of this rule—

''(a) the term 'congressional earmark' means a provision or report language included primarily at the request of a Member, Delegate, Resident Commissioner, or Senator providing, authorizing or recommending a specific amount of discretionary budget authority, credit authority, or other spending authority for a contract, loan, loan guarantee, grant, loan authority, or other expenditure with or to an entity, or targeted to a specific State, locality or Congressional district, other than through a statutory or administrative formula-driven or competitive award process;

''(b) the term 'limited tax benefit' means—

''(1) any revenue provision that—

''(A) provides a Federal tax deduction, credit, exclusion, or preference to a particular beneficiary or limited group of beneficiaries under the Internal Revenue Code of 1986; and

''(B) contains eligibility criteria that are not uniform in application with respect to potential beneficiaries of such provision; or

''(2) any Federal tax provision which provides one beneficiary temporary or permanent transition relief from a change to the Internal Revenue Code of 1986; and

''(c) the term 'limited tariff benefit' means a provision modifying the Harmonized Tariff

Schedule of the United States in a manner that benefits 10 or fewer entities.

''3. A Member may not condition the inclusion of language to provide funding for a congressional earmark, a limited tax benefit, or a limited tariff benefit in any bill or joint resolution (or an accompanying report) or in any conference report on a bill or joint resolution (including an accompanying joint explanatory statement of managers) on any vote cast by another Member, Delegate, or Resident Commissioner.

''4. (a) A Member who requests a congressional earmark, a limited tax benefit, or a limited tariff benefit in any bill or joint resolution (or an accompanying report) or in any conference report on a bill or joint resolution (or an accompanying joint statement of managers) shall provide a written statement to the chairman and ranking member of the committee of jurisdiction, including—

''(1) the name of the Member;

''(2) in the case of a congressional earmark, the name and address of the intended recipient or, if there is no specifically intended recipient, the intended location of the activity;

''(3) in the case of a limited tax or tariff benefit, identification of the individual or entities reasonably anticipated to benefit, to the extent known to the Member;

''(4) the purpose of such congressional earmark or limited tax or tariff benefit; and

''(5) a certification that the Member or spouse has no financial interest in such congressional earmark or limited tax or tariff benefit.

''(b) Each committee shall maintain the written statements transmitted under subparagraph (a). The written statements transmitted under subparagraph (a) for any congressional earmarks, limited tax benefits, or limited tariff benefits included in any measure reported by the committee or conference report filed by the chairman of the committee or any subcommittee thereof shall be published in a searchable format on the committee's or subcommittee's website not later than 48 hours after receipt on such information.

''5. It shall not be in order to consider any bill, resolution, or conference report that contains an earmark included in any classified portion of a report accompanying the measure unless the bill, resolution, or conference report includes to the greatest extent practicable, consistent with the need to protect national security (including intelligence sources and methods), in unclassified language, a general program description, funding level, and the name of the sponsor of that earmark.''.

SEC. 523. PROHIBITION ON FINANCIAL GAIN FROM EARMARKS BY MEMBERS, IMMEDIATE FAMILY OF MEMBERS, STAFF OF MEMBERS, OR IMMEDIATE FAMILY OF STAFF OF MEMBERS.

Rule XXXVII of the Standing Rules of the Senate is amended by adding at the end the following:

''15. (a) No Member shall use his official position to introduce, request, or otherwise aid the progress or passage of a congressional earmark that will financially benefit or otherwise further the pecuniary interest of such Member, the spouse of such Member, the immediate family member of such Member, any employee on the staff of such Member, the spouse of an employee on the staff of such Member, or immediate family member of an employee on the staff of such Member.

''(b) For purposes of this paragraph—

''(1) the term 'immediate family member' means the son, daughter, stepson, stepdaughter, son-in-law, daughter-in-law, mother, father, stepmother, stepfather, mother-in-law, father-in-law, brother, sister, stepbrother, or stepsister of a Member or any employee on the staff (including staff in personal, committee and leadership offices) of a Member; and

''(2) the term 'congressional earmark' shall have the same meaning as in rule XLIV of the Standing Rules of the Senate.''.

SA 2606. Mr. DODD submitted an amendment intended to be proposed by him to the bill H.R. 180, to require the identification of companies that conduct business operations in Sudan, to prohibit United States Government contracts with such companies, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 3 and insert the following:

SEC. 3. TRANSPARENCY IN CAPITAL MARKETS.

(a) LIST OF PERSONS DIRECTLY INVESTING IN OR CONDUCTING BUSINESS OPERATIONS IN CERTAIN SUDANESE SECTORS.—

(1) PUBLICATION OF LIST.—Not later than 6 months after the date of the enactment of this Act and every 6 months thereafter, the President, in consultation with the Secretary of the Treasury, the Secretary of Energy, the Secretary of State, the Securities and Exchange Commission, and the heads of other appropriate Federal departments and agencies, shall, using only publicly available (including proprietary) information, ensure publication in the Federal Register of a list of each person, whether within or outside of the United States, that, as of the date of the publication, has a direct investment in, or is conducting, business operations in Sudan's power production, mineral extraction, oil-related, or military equipment industries, subject to paragraph (2). To the extent practicable, the list shall include a description of the investment made by each such person, including the dollar value, intended purpose, and status of the investment, as of the date of the publication.

(2) EXCEPTIONS.—The President shall exclude a person from the list if all of the business operations by reason of which the person would otherwise be included on the list—

(A) are conducted under contract directly and exclusively with the regional government of southern Sudan;

(B) are conducted under a license from the Office of Foreign Assets Control, or are expressly exempted under Federal law from the requirement to be conducted under such a license;

(C) consist of providing goods or services to marginalized populations of Sudan;

(D) consist of providing goods or services to an internationally recognized peacekeeping force or humanitarian organization;

(E) consist of providing goods or services that are used only to promote health or education;

(F) are conducted by a person that has also undertaken significant humanitarian efforts as described in section 10(14)(B);

(G) have been voluntarily suspended; or

(H) will cease within 1 year after the adoption of a formal plan to cease the operations, as determined by the President.

(3) CONSIDERATION OF SCRUTINIZED BUSINESS OPERATIONS.—The President should give serious consideration to including on the list any company that has a scrutinized business operation with respect to Sudan (within the meaning of section 10(4)).

(4) PRIOR NOTICE TO PERSONS.—The President shall, at least 30 days before the list is published under paragraph (1), notify each person that the President intends to include on the list.

(5) DELAY IN INCLUDING PERSONS ON THE LIST.—After notifying a person under paragraph (4), the President may delay including that person on the list for up to 60 days if the President determines and certifies to the Congress that the person has taken specific and effective actions to terminate the involvement of the person in the activities that resulted in the notification under paragraph (4).

(6) REMOVAL OF PERSONS FROM THE LIST.—The President may remove a person from the list before the next publication of the list under paragraph (1) if the President determines that the person no longer has a direct investment in or is no longer conducting business operations as described in paragraph (1).

(7) ADVANCE NOTICE TO CONGRESS.—Not later than 30 days (or, in the case of the 1st such list, 60 days) before the date by which paragraph (1) requires the list to be published, the President shall submit to the Committees on Financial Services, on Education and Labor, and on Oversight and Government Reform of the House of Representatives and the Committees on Banking, Housing, and Urban Affairs, on Health, Education, Labor, and Pensions, and on Homeland Security and Governmental Affairs of the Senate a copy of the list which the President intends to publish under paragraph (1).

(b) PUBLICATION ON WEBSITE.—The President shall ensure that the list is published on an appropriate, publicly accessible Government website, updating the list as necessary to take into account any person removed from the list under subsection (a)(6).

(c) DEFINITION.—In this section, the term ''investment'' has the meaning given the term in section 4(b)(3).

SA 2607. Mr. DODD submitted an amendment intended to be proposed by him to the bill H.R. 180, to require the identification of companies that conduct business operations in Sudan, to prohibit United States Government contracts with such companies, and for other purposes; which was ordered to lie on the table; as follows:

On page 13, between lines 4 and 5, insert the following:

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for the purposes of carrying out this section.

SA 2608. Ms. SNOWE (for herself, Mr. BINGAMAN, Mr. CARDIN, Ms. MIKULSKI, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 213, strike line 13 and all that follows through page 216, line 6 and insert the following:

SEC. 608. REQUIRING COVERAGE OF DENTAL SERVICES.

(a) REQUIRED COVERAGE OF DENTAL SERVICES.—

(1) IN GENERAL.—Section 2103 (42 U.S.C. 1397cc) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by striking ''subsection (c)(5)'' and inserting ''paragraphs (5) and (6) of subsection (c)''; and

(B) in subsection (c)—

(i) by redesignating paragraph (5) as paragraph (6); and

(ii) by inserting after paragraph (4), the following new paragraph:

''(5) DENTAL SERVICES.—The child health assistance provided to a targeted low-income

child (whether through benchmark coverage or benchmark-equivalent coverage or otherwise) shall include coverage of dental services necessary to—

''(A) prevent disease and promote oral health;

''(B) restore oral structures to health and function; and

''(C) treat emergency conditions.''.

(2) STATE CHILD HEALTH PLAN REQUIREMENT.—Section 2102(a)(7)(B) (42 U.S.C. 1397bb(a)(7)(B)) is amended by inserting ''and services described in section 2103(c)(5)'' after ''emergency services''.

(3) INCLUSION IN BASIC SERVICES FOR BENCHMARK-EQUIVALENT COVERAGE.—Section 2103(c)(1) (42 U.S.C. 1397cc(c)(1)) is amended by adding at the end the following new subparagraph:

''(E) Services described in paragraph (5).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to health benefits coverage provided on or after October 1, 2008.

(b) DENIAL OF DEDUCTION FOR PUNITIVE DAMAGES.—

(1) DISALLOWANCE OF DEDUCTION.—

(A) IN GENERAL.—Section 162(g) (relating to treble damage payments under the antitrust laws) is amended—

(i) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively,

(ii) by striking ''If'' and inserting:

''(1) TREBLE DAMAGES.—If'', and

(iii) by adding at the end the following new paragraph:

''(2) PUNITIVE DAMAGES.—No deduction shall be allowed under this chapter for any amount paid or incurred for punitive damages in connection with any judgment in, or settlement of, any action. This paragraph shall not apply to punitive damages described in section 104(c).''.

(B) CONFORMING AMENDMENT.—The heading for section 162(g) is amended by inserting ''OR PUNITIVE DAMAGES'' after ''LAWS''.

(2) INCLUSION IN INCOME OF PUNITIVE DAMAGES PAID BY INSURER OR OTHERWISE.—

(A) IN GENERAL.—Part II of subchapter B of chapter 1 (relating to items specifically included in gross income) is amended by adding at the end the following new section:

''SEC. 91. PUNITIVE DAMAGES COMPENSATED BY INSURANCE OR OTHERWISE.

''Gross income shall include any amount paid to or on behalf of a taxpayer as insurance or otherwise by reason of the taxpayer's liability (or agreement) to pay punitive damages.''.

(B) REPORTING REQUIREMENTS.—Section 6041 (relating to information at source) is amended by adding at the end the following new subsection:

''(h) SECTION TO APPLY TO PUNITIVE DAMAGES COMPENSATION.—This section shall apply to payments by a person to or on behalf of another person as insurance or otherwise by reason of the other person's liability (or agreement) to pay punitive damages.''.

(C) CONFORMING AMENDMENT.—The table of sections for part II of subchapter B of chapter 1 is amended by adding at the end the following new item:

''Sec. 91. Punitive damages compensated by insurance or otherwise.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to damages paid or incurred on or after the date of the enactment of this Act.

(c) DENIAL OF DEDUCTION FOR CERTAIN FINES, PENALTIES, AND OTHER AMOUNTS.—

(1) IN GENERAL.—Subsection (f) of section 162 (relating to trade or business expenses) is amended to read as follows:

''(f) FINES, PENALTIES, AND OTHER AMOUNTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no deduction otherwise allowable shall be allowed under this chapter for any amount paid or incurred (whether by suit, agreement, or otherwise) to, or at the direction of, a government or entity described in paragraph (4) in relation to the violation of any law or the investigation or inquiry by such government or entity into the potential violation of any law.

''(2) EXCEPTION FOR AMOUNTS CONSTITUTING RESTITUTION OR PAID TO COME INTO COMPLIANCE WITH LAW.—Paragraph (1) shall not apply to any amount which—

''(A) the taxpayer establishes—

''(i) constitutes restitution (including remediation of property) for damage or harm caused by or which may be caused by the violation of any law or the potential violation of any law, or

''(ii) is paid to come into compliance with any law which was violated or involved in the investigation or inquiry, and

''(B) is identified as restitution or as an amount paid to come into compliance with the law, as the case may be, in the court order or settlement agreement.

A taxpayer shall not meet the requirements of subparagraph (A) solely by reason an identification under subparagraph (B). This paragraph shall not apply to any amount paid or incurred as reimbursement to the government or entity for the costs of any investigation or litigation.

''(3) EXCEPTION FOR AMOUNTS PAID OR INCURRED AS THE RESULT OF CERTAIN COURT ORDERS.—Paragraph (1) shall not apply to any amount paid or incurred by order of a court in a suit in which no government or entity described in paragraph (4) is a party.

''(4) CERTAIN NONGOVERNMENTAL REGULATORY ENTITIES.—An entity is described in this paragraph if it is—

''(A) a nongovernmental entity which exercises self-regulatory powers (including imposing sanctions) in connection with a qualified board or exchange (as defined in section 1256(g)(7)), or

''(B) to the extent provided in regulations, a nongovernmental entity which exercises self-regulatory powers (including imposing sanctions) as part of performing an essential governmental function.

''(5) EXCEPTION FOR TAXES DUE.—Paragraph (1) shall not apply to any amount paid or incurred as taxes due.''.

(2) REPORTING OF DEDUCTIBLE AMOUNTS.—

(A) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 is amended by inserting after section 6050V the following new section:

''SEC. 6050W. INFORMATION WITH RESPECT TO CERTAIN FINES, PENALTIES, AND OTHER AMOUNTS.

''(a) REQUIREMENT OF REPORTING.—

''(1) IN GENERAL.—The appropriate official of any government or entity which is described in section 162(f)(4) which is involved in a suit or agreement described in paragraph (2) shall make a return in such form as determined by the Secretary setting forth—

''(A) the amount required to be paid as a result of the suit or agreement to which paragraph (1) of section 162(f) applies,

''(B) any amount required to be paid as a result of the suit or agreement which constitutes restitution or remediation of property, and

''(C) any amount required to be paid as a result of the suit or agreement for the purpose of coming into compliance with any law which was violated or involved in the investigation or inquiry.

''(2) SUIT OR AGREEMENT DESCRIBED.—

''(A) IN GENERAL.—A suit or agreement is described in this paragraph if—

''(i) it is—

''(I) a suit with respect to a violation of any law over which the government or entity has authority and with respect to which there has been a court order, or

''(II) an agreement which is entered into with respect to a violation of any law over which the government or entity has authority, or with respect to an investigation or inquiry by the government or entity into the potential violation of any law over which such government or entity has authority, and

''(ii) the aggregate amount involved in all court orders and agreements with respect to the violation, investigation, or inquiry is $600 or more.

''(B) ADJUSTMENT OF REPORTING THRESHOLD.—The Secretary may adjust the $600 amount in subparagraph (A)(ii) as necessary in order to ensure the efficient administration of the internal revenue laws.

''(3) TIME OF FILING.—The return required under this subsection shall be filed not later than—

''(A) 30 days after the date on which a court order is issued with respect to the suit or the date the agreement is entered into, as the case may be, or

''(B) the date specified Secretary.

''(b) STATEMENTS TO BE FURNISHED TO INDIVIDUALS INVOLVED IN THE SETTLEMENT.—Every person required to make a return under subsection (a) shall furnish to each person who is a party to the suit or agreement a written statement showing—

''(1) the name of the government or entity, and

''(2) the information supplied to the Secretary under subsection (a)(1).

The written statement required under the preceding sentence shall be furnished to the person at the same time the government or entity provides the Secretary with the information required under subsection (a).

''(c) APPROPRIATE OFFICIAL DEFINED.—For purposes of this section, the term 'appropriate official' means the officer or employee having control of the suit, investigation, or inquiry or the person appropriately designated for purposes of this section.''.

(B) CONFORMING AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by inserting after the item relating to section 6050V the following new item:

''Sec. 6050W. Information with respect to certain fines, penalties, and other amounts.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to amounts paid or incurred on or after the date of the enactment of this Act, except that such amendments shall not apply to amounts paid or incurred under any binding order or agreement entered into before such date. Such exception shall not apply to an order or agreement requiring court approval unless the approval was obtained before such date.

SA 2609. Ms. SNOWE (for herself, Mr. BINGAMAN, Mr. CARDIN, Ms. MIKULSKI, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 216, between lines 6 and 7, insert the following:

(b) AMOUNT APPROPRIATED FOR DENTAL HEALTH GRANTS.—Notwithstanding subsection (e) of section 2114 of the Social Security Act, as added by this section, out of any

funds in the Treasury not otherwise appropriated, there is appropriated, $500,000,000 for the period of fiscal years 2008 through 2012, to remain available until expended, for the purpose of awarding grants to States under such section. Amounts appropriated under this subsection and paid under the authority of such section 2114 shall be in addition to amounts appropriated under section 2104 of the Social Security Act (42 U.S.C. 1397dd) and paid to States in accordance with section 2105 of such Act (42 U.S.C. 1397ee).

(c) DENIAL OF DEDUCTION FOR PUNITIVE DAMAGES.—

(1) DISALLOWANCE OF DEDUCTION.—

(A) IN GENERAL.—Section 162(g) (relating to treble damage payments under the antitrust laws) is amended—

(i) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively,

(ii) by striking ''If'' and inserting:

''(1) TREBLE DAMAGES.—If'', and

(iii) by adding at the end the following new paragraph:

''(2) PUNITIVE DAMAGES.—No deduction shall be allowed under this chapter for any amount paid or incurred for punitive damages in connection with any judgment in, or settlement of, any action. This paragraph shall not apply to punitive damages described in section 104(c).''.

(B) CONFORMING AMENDMENT.—The heading for section 162(g) is amended by inserting ''OR PUNITIVE DAMAGES'' after ''LAWS''.

(2) INCLUSION IN INCOME OF PUNITIVE DAMAGES PAID BY INSURER OR OTHERWISE.—

(A) IN GENERAL.—Part II of subchapter B of chapter 1 (relating to items specifically included in gross income) is amended by adding at the end the following new section:

''SEC. 91. PUNITIVE DAMAGES COMPENSATED BY INSURANCE OR OTHERWISE.

''Gross income shall include any amount paid to or on behalf of a taxpayer as insurance or otherwise by reason of the taxpayer's liability (or agreement) to pay punitive damages.''.

(B) REPORTING REQUIREMENTS.—Section 6041 (relating to information at source) is amended by adding at the end the following new subsection:

''(h) SECTION TO APPLY TO PUNITIVE DAMAGES COMPENSATION.—This section shall apply to payments by a person to or on behalf of another person as insurance or otherwise by reason of the other person's liability (or agreement) to pay punitive damages.''.

(C) CONFORMING AMENDMENT.—The table of sections for part II of subchapter B of chapter 1 is amended by adding at the end the following new item:

''Sec. 91. Punitive damages compensated by insurance or otherwise.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to damages paid or incurred on or after the date of the enactment of this Act.

(d) DENIAL OF DEDUCTION FOR CERTAIN FINES, PENALTIES, AND OTHER AMOUNTS.—

(1) IN GENERAL.—Subsection (f) of section 162 (relating to trade or business expenses) is amended to read as follows:

''(f) FINES, PENALTIES, AND OTHER AMOUNTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no deduction otherwise allowable shall be allowed under this chapter for any amount paid or incurred (whether by suit, agreement, or otherwise) to, or at the direction of, a government or entity described in paragraph (4) in relation to the violation of any law or the investigation or inquiry by such government or entity into the potential violation of any law.

''(2) EXCEPTION FOR AMOUNTS CONSTITUTING RESTITUTION OR PAID TO COME INTO COMPLIANCE WITH LAW.—Paragraph (1) shall not apply to any amount which—

''(A) the taxpayer establishes—

''(i) constitutes restitution (including remediation of property) for damage or harm caused by or which may be caused by the violation of any law or the potential violation of any law, or

''(ii) is paid to come into compliance with any law which was violated or involved in the investigation or inquiry, and

''(B) is identified as restitution or as an amount paid to come into compliance with the law, as the case may be, in the court order or settlement agreement.

A taxpayer shall not meet the requirements of subparagraph (A) solely by reason an identification under subparagraph (B). This paragraph shall not apply to any amount paid or incurred as reimbursement to the government or entity for the costs of any investigation or litigation.

''(3) EXCEPTION FOR AMOUNTS PAID OR INCURRED AS THE RESULT OF CERTAIN COURT ORDERS.—Paragraph (1) shall not apply to any amount paid or incurred by order of a court in a suit in which no government or entity described in paragraph (4) is a party.

''(4) CERTAIN NONGOVERNMENTAL REGULATORY ENTITIES.—An entity is described in this paragraph if it is—

''(A) a nongovernmental entity which exercises self-regulatory powers (including imposing sanctions) in connection with a qualified board or exchange (as defined in section 1256(g)(7)), or

''(B) to the extent provided in regulations, a nongovernmental entity which exercises self-regulatory powers (including imposing sanctions) as part of performing an essential governmental function.

''(5) EXCEPTION FOR TAXES DUE.—Paragraph (1) shall not apply to any amount paid or incurred as taxes due.''.

(2) REPORTING OF DEDUCTIBLE AMOUNTS.—

(A) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 is amended by inserting after section 6050V the following new section:

''SEC. 6050W. INFORMATION WITH RESPECT TO CERTAIN FINES, PENALTIES, AND OTHER AMOUNTS.

''(a) REQUIREMENT OF REPORTING.—

''(1) IN GENERAL.—The appropriate official of any government or entity which is described in section 162(f)(4) which is involved in a suit or agreement described in paragraph (2) shall make a return in such form as determined by the Secretary setting forth—

''(A) the amount required to be paid as a result of the suit or agreement to which paragraph (1) of section 162(f) applies,

''(B) any amount required to be paid as a result of the suit or agreement which constitutes restitution or remediation of property, and

''(C) any amount required to be paid as a result of the suit or agreement for the purpose of coming into compliance with any law which was violated or involved in the investigation or inquiry.

''(2) SUIT OR AGREEMENT DESCRIBED.—

''(A) IN GENERAL.—A suit or agreement is described in this paragraph if—

''(i) it is—

''(I) a suit with respect to a violation of any law over which the government or entity has authority and with respect to which there has been a court order, or

''(II) an agreement which is entered into with respect to a violation of any law over which the government or entity has authority, or with respect to an investigation or inquiry by the government or entity into the potential violation of any law over which such government or entity has authority, and

''(ii) the aggregate amount involved in all court orders and agreements with respect to the violation, investigation, or inquiry is $600 or more.

''(B) ADJUSTMENT OF REPORTING THRESHOLD.—The Secretary may adjust the $600 amount in subparagraph (A)(ii) as necessary in order to ensure the efficient administration of the internal revenue laws.

''(3) TIME OF FILING.—The return required under this subsection shall be filed not later than—

''(A) 30 days after the date on which a court order is issued with respect to the suit or the date the agreement is entered into, as the case may be, or

''(B) the date specified Secretary.

''(b) STATEMENTS TO BE FURNISHED TO INDIVIDUALS INVOLVED IN THE SETTLEMENT.—Every person required to make a return under subsection (a) shall furnish to each person who is a party to the suit or agreement a written statement showing—

''(1) the name of the government or entity, and

''(2) the information supplied to the Secretary under subsection (a)(1).

The written statement required under the preceding sentence shall be furnished to the person at the same time the government or entity provides the Secretary with the information required under subsection (a).

''(c) APPROPRIATE OFFICIAL DEFINED.—For purposes of this section, the term 'appropriate official' means the officer or employee having control of the suit, investigation, or inquiry or the person appropriately designated for purposes of this section.''.

(B) CONFORMING AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by inserting after the item relating to section 6050V the following new item:

''Sec. 6050W. Information with respect to certain fines, penalties, and other amounts.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to amounts paid or incurred on or after the date of the enactment of this Act, except that such amendments shall not apply to amounts paid or incurred under any binding order or agreement entered into before such date. Such exception shall not apply to an order or agreement requiring court approval unless the approval was obtained before such date.

SA 2610. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 133, strike line 4 and all that follows through page 165, line 2, and insert the following:

SEC. 401. IMPROVED STATE OPTION FOR OFFERING PREMIUM ASSISTANCE FOR COVERAGE THROUGH PRIVATE PLANS.

(a) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 301(c) is amended by adding at the end the following:

''(10) ADDITIONAL STATE OPTION FOR OFFERING PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and

have access to such coverage in accordance with the requirements of this paragraph.

''(B) QUALIFIED EMPLOYER SPONSORED COVERAGE.—

''(i) IN GENERAL.—In this paragraph, the term 'qualified employer sponsored coverage' means a group health plan or health insurance coverage offered through an employer that is—

''(I) substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2);

''(II) made similarly available to all of the employer's employees and for which the employer makes a contribution to the premium that is not less for employees receiving a premium assistance subsidy under any option available under the State child health plan under this title or the State plan under title XIX to provide such assistance than the employer contribution provided for all other employees; and

''(III) cost-effective, as determined under clause (ii).

''(ii) COST-EFFECTIVENESS.—A group health plan or health insurance coverage offered through an employer shall be considered to be cost-effective if—

''(I) the marginal premium cost to purchase family coverage through the employer is less than the State cost of providing child health assistance through the State child health plan for all the children in the family who are targeted low-income children; or

''(II) the marginal premium cost between individual coverage and purchasing family coverage through the employer is not greater than 175 percent of the cost to the State to provide child health assistance through the State child health plan for a targeted low-income child.

''(iii) HIGH DEDUCTIBLE HEALTH PLANS INCLUDED.—The term 'qualified employer sponsored coverage' includes a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (as defined under section 223(d) of such Code).

''(C) PREMIUM ASSISTANCE SUBSIDY.—

''(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan, subject to the annual aggregate cost-sharing limit applied under section 2103(e)(3)(B).

''(ii) STATE PAYMENT OPTION.—Subject to clause (iii), a State may provide a premium assistance subsidy directly to an employer or as reimbursement to an employee for out-of-pocket expenditures.

''(iii) REQUIREMENT FOR DIRECT PAYMENT TO EMPLOYEE.—A State shall not pay a premium assistance subsidy directly to the employee, unless the State has established procedures to ensure that the targeted low-income child on whose behalf such payments are made are actually enrolled in the qualified employer sponsored coverage.

''(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

''(v) STATE OPTION TO REQUIRE ACCEPTANCE OF SUBSIDY.—A State may condition the provision of child health assistance under the State child health plan for a targeted low-income child on the receipt of a premium assistance subsidy for enrollment in qualified employer sponsored coverage if the State determines the provision of such a subsidy to be more cost-effective in accordance with subparagraph (B)(ii).

''(vi) NOT TREATED AS INCOME.—Notwithstanding any other provision of law, a premium assistance subsidy provided in accordance with this paragraph shall not be treated as income to the child or the parent of the child for whom such subsidy is provided.

''(D) NO REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND ADDITIONAL COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

''(i) IN GENERAL.—A State that elects the option to provide a premium assistance subsidy under this paragraph shall not be required to provide a targeted low-income child enrolled in qualified employer sponsored coverage with supplemental coverage for items or services that are not covered, or are only partially covered, under the qualified employer sponsored coverage or cost-sharing protection other than the protection required under section 2103(e)(3)(B).

''(ii) NOTICE OF COST-SHARING REQUIREMENTS.—A State shall provide a targeted low-income child or the parent of such a child (as appropriate) who is provided with a premium assistance subsidy in accordance with this paragraph with notice of the cost-sharing requirements and limitations imposed under the qualified employer sponsored coverage in which the child is enrolled upon the enrollment of the child in such coverage and annually thereafter.

''(iii) RECORD KEEPING REQUIREMENTS.—A State may require a parent of a targeted low-income child that is enrolled in qualified employer-sponsored coverage to bear the responsibility for keeping track of out-of-pocket expenditures incurred for cost-sharing imposed under such coverage and to notify the State when the limit on such expenditures imposed under section 2103(e)(3)(B) has been reached for a year from the effective date of enrollment for such year.

''(iv) STATE OPTION FOR REIMBURSEMENT.—A State may retroactively reimburse a parent of a targeted low-income child for out-of-pocket expenditures incurred after reaching the 5 percent cost-sharing limitation imposed under section 2103(e)(3)(B) for a year.

''(E) 6-MONTH WAITING PERIOD REQUIRED.—A State shall impose at least a 6-month waiting period from the time an individual is enrolled in private health insurance prior to the provision of a premium assistance subsidy for a targeted low-income child in accordance with this paragraph.

''(F) NON APPLICATION OF WAITING PERIOD FOR ENROLLMENT IN THE STATE MEDICAID PLAN OR THE STATE CHILD HEALTH PLAN.—A targeted low-income child provided a premium assistance subsidy in accordance with this paragraph who loses eligibility for such subsidy shall not be treated as having been enrolled in private health insurance coverage for purposes of applying any waiting period imposed under the State child health plan or the State plan under title XIX for the enrollment of the child under such plan.

''(G) ASSURANCE OF SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF ELIGIBILITY FOR PREMIUM SUBSIDY ASSISTANCE.—No payment shall be made under subsection (a) for amounts expended for the provision of premium assistance subsidies under this paragraph unless a State provides assurances to the Secretary that the State has in effect laws requiring a group health plan, a health insurance issuer offering group health insurance coverage in connection with a group health plan, and a self-funded health plan, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a child of such an employee if the child is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the employee's child becomes eligible for a premium assistance subsidy under this paragraph.

''(H) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect on June 28, 2007.

''(I) NOTICE OF AVAILABILITY.—A State shall—

''(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer sponsored coverage;

''(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

''(iii) establish such other procedures as the State determines necessary to ensure that parents are informed of the availability of such subsidies under the State child health plan.''.

(b) APPLICATION TO MEDICAID.—Section 1906 (42 U.S.C. 1396e) is amended by inserting after subsection (c) the following:

''(d) The provisions of section 2105(c)(10) shall apply to a child who is eligible for medical assistance under the State plan in the same manner as such provisions apply to a targeted low-income child under a State child health plan under title XXI. Section 1902(a)(34) shall not apply to a child who is provided a premium assistance subsidy under the State plan in accordance with the preceding sentence.''.

SA 2611. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 133, strike line 4 and all that follows through page 165, line 2, and insert the following:

SEC. 401. PREMIUM ASSISTANCE FOR HIGHER INCOME CHILDREN AND PREGNANT WOMEN WITH ACCESS TO EMPLOYER-SPONSORED COVERAGE.

(a) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 301(c) is amended by adding at the end the following:

''(10) PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—Beginning with fiscal year 2008, a State may only provide child health assistance for a targeted low-income child or a pregnant woman whose family income exceeds 200 percent of the poverty line and who has access to qualified employer sponsored coverage (as defined in subparagraph (B)) through the provision of a premium assistance subsidy in accordance with the requirements of this paragraph. The enhanced FMAP under subsection (a)(1) shall be zero with respect to any expenditures for providing child health assistance for a targeted low-income child or pregnant woman described in the preceding sentence in any manner other than through the provision of such a subsidy.

''(B) QUALIFIED EMPLOYER SPONSORED COVERAGE.—

''(i) IN GENERAL.—In this paragraph, the term 'qualified employer sponsored coverage' means a group health plan or health insurance coverage offered through an employer that is—

''(I) substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2);

''(II) for which the employer contribution toward any premium for such coverage is at least 50 percent (75 percent, in the case of an employer with more than 50 employees);

''(III) made similarly available to all of the employer's employees and for which the employer makes a contribution to the premium that is not less for employees receiving a premium assistance subsidy under any option available under the State child health plan under this title or the State plan under title XIX to provide such assistance than the employer contribution provided for all other employees; and

''(IV) cost-effective, as determined under clause (ii).

''(ii) COST-EFFECTIVENESS.—A group health plan or health insurance coverage offered through an employer shall be considered to be cost-effective if—

''(I) the marginal premium cost to purchase family coverage through the employer is less than the State cost of providing child health assistance through the State child health plan for all the children in the family who are targeted low-income children; or

''(II) the marginal premium cost between individual coverage and purchasing family coverage through the employer is not greater than 175 percent of the cost to the State to provide child health assistance through the State child health plan for a targeted low-income child.

''(iii) HIGH DEDUCTIBLE HEALTH PLANS INCLUDED.—The term 'qualified employer sponsored coverage' includes a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (as defined under section 223(d) of such Code).

''(C) PREMIUM ASSISTANCE SUBSIDY.—

''(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan, subject to the annual aggregate cost-sharing limit applied under section 2103(e)(3)(B).

''(ii) STATE PAYMENT OPTION.—Subject to clause (iii), a State may provide a premium assistance subsidy directly to an employer or as reimbursement to an employee for out-of-pocket expenditures.

''(iii) REQUIREMENT FOR DIRECT PAYMENT TO EMPLOYEE.—A State shall not pay a premium assistance subsidy directly to the employee, unless the State has established procedures to ensure that the targeted low-income child on whose behalf such payments are made are actually enrolled in the qualified employer sponsored coverage.

''(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

''(v) STATE OPTION TO REQUIRE ACCEPTANCE OF SUBSIDY.—A State may condition the provision of child health assistance under the State child health plan for a targeted low-income child on the receipt of a premium assistance subsidy for enrollment in qualified employer sponsored coverage if the State determines the provision of such a subsidy to be more cost-effective in accordance with subparagraph (B)(ii).

''(vi) NOT TREATED AS INCOME.—Notwithstanding any other provision of law, a premium assistance subsidy provided in accordance with this paragraph shall not be treated as income to the child or the parent of the child for whom such subsidy is provided.

''(D) NO REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND ADDITIONAL COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

''(i) IN GENERAL.—A State that elects the option to provide a premium assistance subsidy under this paragraph shall not be required to provide a targeted low-income child enrolled in qualified employer sponsored coverage with supplemental coverage for items or services that are not covered, or are only partially covered, under the qualified employer sponsored coverage or cost-sharing protection other than the protection required under section 2103(e)(3)(B).

''(ii) NOTICE OF COST-SHARING REQUIREMENTS.—A State shall provide a targeted low-income child or the parent of such a child (as appropriate) who is provided with a premium assistance subsidy in accordance with this paragraph with notice of the cost-sharing requirements and limitations imposed under the qualified employer sponsored coverage in which the child is enrolled upon the enrollment of the child in such coverage and annually thereafter.

''(iii) RECORD KEEPING REQUIREMENTS.—A State may require a parent of a targeted low-income child that is enrolled in qualified employer-sponsored coverage to bear the responsibility for keeping track of out-of-pocket expenditures incurred for cost-sharing imposed under such coverage and to notify the State when the limit on such expenditures imposed under section 2103(e)(3)(B) has been reached for a year from the effective date of enrollment for such year.

''(iv) STATE OPTION FOR REIMBURSEMENT.—A State may retroactively reimburse a parent of a targeted low-income child for out-of-pocket expenditures incurred after reaching the 5 percent cost-sharing limitation imposed under section 2103(e)(3)(B) for a year.

''(E) 6-MONTH WAITING PERIOD REQUIRED.—A State shall impose at least a 6-month waiting period from the time an individual is enrolled in private health insurance prior to the provision of a premium assistance subsidy for a targeted low-income child in accordance with this paragraph.

''(F) NON APPLICATION OF WAITING PERIOD FOR ENROLLMENT IN THE STATE MEDICAID PLAN OR THE STATE CHILD HEALTH PLAN.—A targeted low-income child provided a premium assistance subsidy in accordance with this paragraph who loses eligibility for such subsidy shall not be treated as having been enrolled in private health insurance coverage for purposes of applying any waiting period imposed under the State child health plan or the State plan under title XIX for the enrollment of the child under such plan.

''(G) ASSURANCE OF SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF ELIGIBILITY FOR PREMIUM SUBSIDY ASSISTANCE.—No payment shall be made under subsection (a) for amounts expended for the provision of premium assistance subsidies under this paragraph unless a State provides assurances to the Secretary that the State has in effect laws requiring a group health plan, a health insurance issuer offering group health insurance coverage in connection with a group health plan, and a self-funded health plan, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a child of such an employee if the child is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the employee's child becomes eligible for a premium assistance subsidy under this paragraph.

''(H) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect on June 28, 2007, for targeted low-income children or pregnant women whose family income does not exceed 200 percent of the poverty line.

''(I) NOTICE OF AVAILABILITY.—A State shall—

''(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer sponsored coverage and the requirement to provide such subsidies to the individuals described in subparagraph (A);

''(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy, or if required, to obtain such subsidies; and

''(iii) establish such other procedures as the State determines necessary to ensure that parents are informed of the availability of such subsidies under the State child health plan.''.

(b) APPLICATION TO MEDICAID.—Section 1906 (42 U.S.C. 1396e) is amended by inserting after subsection (c) the following:

''(d) The provisions of section 2105(c)(10) shall apply to a child who is eligible for medical assistance under the State plan in the same manner as such provisions apply to a targeted low-income child under a State child health plan under title XXI. Section 1902(a)(34) shall not apply to a child who is provided a premium assistance subsidy under the State plan in accordance with the preceding sentence.''.

SA 2612. Mr. STEVENS submitted an amendment intended to be proposed by him to the bill S. 1, to provide greater transparency in the legislative process; which was ordered to lie on the table; as follows:

Strike section 544 (c) of the amendment and insert the following:

(c) LIMITED FLIGHT EXCEPTION.—

(1) IN GENERAL.—Paragraph 1 of rule XXXV of the Standing Rules of the Senate is amended by adding at the end the following:

''(h) For purposes of subparagraph (c)(1) and rule XXXVIII, if there is not more than 1 regularly scheduled flight daily from a point in a Member's State to another point within that Member's State, the Select Committee on Ethics may provide a waiver to the requirements in subparagraph (c)(1) (except in those cases where regular air service is not available between 2 cities) if—

''(1) there is no appearance of or actual conflict of interest; and

''(2) the Member has the trip approved by the committee at a rate determined by the committee.

In determining rates under clause (2), the committee may consider Ethics Committee Interpretive Ruling 412.''.

(2) DISCLOSURE.—

(A) RULES.—Paragraph 2 of rule XXXV of the Standing Rules of the Senate is amended by adding at the end the following:

''(g) A Member, officer, or employee of the Senate shall—

''(1) disclose a flight on an aircraft that is not licensed by the Federal Aviation Administration to operate for compensation or hire, excluding a flight on an aircraft owned, operated, or leased by a governmental entity, taken in connection with the duties of the Member, officer, or employee as an officeholder or Senate officer or employee; and

''(2) with respect to the flight, file a report with the Secretary of the Senate, including the date, destination, and owner or lessee of the aircraft, the purpose of the trip, and the persons on the trip, except for any person flying the aircraft.

This subparagraph shall apply to flights approved under paragraph 1(h).''.

(B) FECA.—Section 304(b) of the Federal Election Campaign Act of 1971 (2 U.S.C. 434(b)) is amended—

(i) by striking ''and'' at the end of paragraph (7);

(ii) by striking the period at the end of paragraph (8) and inserting ''; and''; and

(iii) by adding at the end the following:

''(9) in the case of a principal campaign committee of a candidate (other than a candidate for election to the office of President or Vice President), any flight taken by the candidate (other than a flight designated to transport the President, Vice President, or a candidate for election to the office of President or Vice President) during the reporting period on an aircraft that is not licensed by the Federal Aviation Administration to operate for compensation or hire, together with the following information:

''(A) The date of the flight.

''(B) The destination of the flight.

''(C) The owner or lessee of the aircraft.

''(D) The purpose of the flight.

''(E) The persons on the flight, except for any person flying the aircraft.''.

(C) PUBLIC AVAILABILITY.—Paragraph 2(e) of rule XXXV of the Standing Rules of the Senate is amended to read as follows:

''(e) The Secretary of the Senate shall make available to the public all disclosures filed pursuant to subparagraphs (f) and (g) as soon as possible after they are received and such matters shall be posted on the Member's official website but no later than 30 days after the trip or flight.''.

(D) REPEAL.—Section 601 of this Act shall be null and void.

SA 2613. Mr. FEINGOLD (for himself, Mr. GRAHAM, Mr. VOINOVICH, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. GAO REPORT ON STATE HEALTH CARE REFORM INITIATIVES.

(a) REPORT.—Not later than November 30, 2008, the Comptroller General of the United States shall submit to Congress a report on State health care reform initiatives.

(b) ELEMENTS.—The report required by subsection (a) shall include the following:

(1) ASSESSMENT.—An assessment of State efforts to reexamine health care delivery and health insurance systems and to expand access of residents to health insurance and health care services, including the following:

(A) An overview of State approaches to reexamining health care delivery and insurance.

(B) Whether and to what extent State health care initiatives have resulted in improved access to health care and insurance.

(C) The extent to which public and private cooperation has occurred in State health care initiatives.

(D) Outcomes of State insurance coverage mandates.

(E) The effects of increased health care costs on State fiscal choices.

(F) The effects of Federal law and funding on State health care initiatives and fiscal choices.

(G) Outcomes of State efforts to increase health care quality and control costs.

(2) POTENTIAL ROLE OF CONGRESS.—Recommendations regarding the potential role of Congress in supporting State-based reform efforts, including (but not limited to) the following:

(A) Enacting changes in Federal law that would facilitate State-based health reform and expansion efforts.

(B) Creating new or realigning existing Federal funding mechanisms to support State-based reform and expansion efforts.

(C) Expanding existing Federal health insurance programs and increasing other sources of Federal health care funding to support State-based health reform and expansion efforts.

SA 2614. Mr. FEINGOLD (for himself, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. AUTOMATED DEFIBRILLATION IN ADAM'S MEMORY REAUTHORIZATION.

Section 312(e) of the Public Health Service Act (42 U.S.C. 244(e)) is amended in the first sentence by striking ''fiscal year 2003'' and all that follows through ''2006'' and inserting ''for each of fiscal years 2003 through 2011''.

SA 2615. Mrs. FEINSTEIN (for herself and Mrs. BOXER) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. AUTHORITY TO CONTINUE PROVIDING ADULT DAY HEALTH SERVICES APPROVED UNDER A STATE MEDICAID PLAN.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary shall not—

(1) withhold, suspend, disallow, or otherwise deny Federal financial participation under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for the provision of adult day health care services, day activity and health services, or adult medical day care services, as defined under a State medicaid plan approved during or before 1994, during such period if such services are provided consistent with such definition and the requirements of such plan; or

(2) withdraw Federal approval of any such State plan or part thereof regarding the provision of such services (by regulation or otherwise).

(b) PERIOD DESCRIBED.—The period described in this subsection is the period that begins on November 3, 2005, and ends on March 1, 2009.

SA 2616. Mrs. FEINSTEIN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PERMITTING LOCAL PUBLIC AGENCIES TO ACT AS MEDICAID ENROLLMENT BROKERS.

Section 1903(b)(4) (42 U.S.C. 1396b(b)(4)) is amended by adding at the end the following new subparagraph:

''(C)(i) Subparagraphs (A) and (B) shall not apply in the case of a local public agency that is acting as an enrollment broker under a contract or memorandum with a State medicaid agency, provided the local public agency does not have a direct or indirect financial interest with any medicaid managed care plan for which it provides enrollment broker services.

''(ii) In determining whether a local public agency has a direct or indirect financial interest with a medicaid managed care plan under clause (i), the status of a local public agency as a contractor of the plan does not constitute having a direct or indirect financial interest with the plan.''.

SA 2617. Mrs. MCCASKILL (for herself and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 223, strike line 20 and all that follows through page 227, line 19, and insert the following:

(2) by striking ''information relating to a substantial violation of law related to a contract (including the competition for or negotiation of a contract)'' and inserting ''information that the employee reasonably believes is evidence of gross mismanagement of a Department of Defense contract, grant, or direct payment if the United States Government provides any portion of the money or property which is requested or demanded, a gross waste of Department of Defense funds, a substantial and specific danger to public health or safety, or a violation of law related to a Department of Defense contract (including the competition for or negotiation of a contract), grant, or direct payment if the United States Government provides any portion of the money or property which is requested or demanded''.

(b) ACCELERATION OF SCHEDULE FOR DENYING RELIEF OR PROVIDING REMEDY.—Subsection (c) of such section is amended—

(1) in paragraph (1)—

(A) by inserting after ''(1)'' the following: ''Not later than 90 days after receiving an Inspector General report pursuant to subsection (b), the head of the agency concerned shall determine whether the contractor concerned has subjected the complainant to a reprisal prohibited under subsection (a).''; and

(B) by adding at the end the following new subparagraphs:

''(D) In the event the disclosure relates to a cost-plus contract, prohibit the contractor from receiving one or more award fee payments to which the contractor would otherwise be eligible until such time as the contractor takes the actions ordered by the head of the agency pursuant to subparagraphs (A) through (C).

''(E) Take the reprisal into consideration in any past performance evaluation of the contractor for the purpose of a contract award.'';

(2) by redesignating paragraph (3) as paragraph (4); and

(3) by inserting after paragraph (2) the following new paragraph:

''(3)(A) In the case of a contract covered by subsection (f), an employee of a contractor who has been discharged, demoted, or otherwise discriminated against as a reprisal for a disclosure covered by subsection (a) or who is aggrieved by the determination made pursuant to paragraph (1) or by an action that the agency head has taken or failed to take pursuant to such determination may, after exhausting his or her administrative remedies, bring a de novo action at law or equity against the contractor to seek compensatory damages and other relief available under this section in the appropriate district court of the United States, which shall have jurisdiction over such an action without regard to the amount in controversy. Such an action shall, at the request of either party to the action, be tried by the court with a jury.

''(B) An employee shall be deemed to have exhausted his or her administrative remedies for the purpose of this paragraph—

''(i) 90 days after the receipt of a written determination under paragraph (1); or

''(ii) 15 months after a complaint is submitted under subsection (b), if a determination by an agency head has not been made by that time and such delay is not shown to be due to the bad faith of the complainant.''.

(c) LEGAL BURDEN OF PROOF.—Such section is further amended—

(1) by redesignating subsection (e) as subsection (g); and

(2) by inserting after subsection (d) the following new subsection:

''(e) LEGAL BURDEN OF PROOF.—The legal burdens of proof specified in section 1221(e) of title 5 shall be controlling for the purposes of any investigation conducted by an inspector general, decision by the head of an agency, or hearing to determine whether discrimination prohibited under this section has occurred.''.

(d) REQUIREMENT TO NOTIFY EMPLOYEES OF RIGHTS RELATED TO PROTECTION FROM REPRISAL.—Such section, as amended by subsection (c), is further amended by inserting after subsection (e) the following new subsection:

''(f) NOTICE OF RIGHTS RELATED TO PROTECTION FROM REPRISAL.—

''(1) IN GENERAL.—Each Department of Defense contract in excess of $5,000,000, other than a contract for the purchase of commercial items, shall include a clause requiring the contractor to ensure that all employees of the contractor who are working on Department of Defense contracts are notified of—

''(A) their rights under this section;

''(B) the fact that the restrictions imposed by any employee contract, employee agreement, or non-disclosure agreement may not supersede, conflict with, or otherwise alter the employee rights provided for under this section; and

''(C) the telephone number for the whistleblower hotline of the Inspector General of the Department of Defense.

''(2) FORM OF NOTICE.—The notice required by paragraph (1) shall be made by posting the required information at a prominent place in each workplace where employees working on the contract regularly work.''.

(e) DEFINITIONS.—Subsection (g) of such section, as redesignated by subsection (c)(1), is amended—

(1) in paragraph (4), by inserting after ''an agency'' the following: ''and includes any person receiving funds covered by the prohibition against reprisals in subsection (a)'';

(2) in paragraph (5), by inserting after ''1978'' the following: ''and any Inspector General that receives funding from or is under the jurisdiction of the Secretary of Defense''; and

(3) by adding at the end the following new paragraphs:

''(6) The term 'employee' means an individual (as defined by section 2105 of title 5) or any individual or organization performing services for a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded (including as an employee of an organization).

''(7) The term 'Department of Defense funds' includes funds controlled by the Department of Defense and funds for which the Department of Defense may be reasonably regarded as responsible to a third party.''.

SA 2618. Mr. WEBB submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

At the end of title VII, insert the following:

SEC. ___. ELIMINATION OF DEFERRAL OF TAXATION OF CERTAIN INCOME OF CONTROLLED FOREIGN CORPORATIONS.

(a) IN GENERAL.—Section 952 (relating to subpart F income defined) is amended by adding at the end the following new subsection:

''(e) SPECIAL APPLICATION OF SUBPART.—

''(1) IN GENERAL.—For taxable years beginning after December 31, 2007, notwithstanding any other provision of this subpart, the term 'subpart F income' means, in the case of any controlled foreign corporation, the income of such corporation derived from any foreign country.

''(2) APPLICABLE RULES.—Rules similar to the rules under the last sentence of subsection (a) and subsection (d) shall apply to this subsection.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years of controlled foreign corporations beginning after December 31, 2007, and to taxable years of United States shareholders with or within which such taxable years of such corporations end.

SA 2619. Mr. NELSON of Florida (for himself and Mr. ALEXANDER) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 218, line 16, strike ''$10.00'' and insert ''$3.00''.

SA 2620. Mrs. HUTCHISON submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 110 and insert the following:

SEC. 110. COVERAGE FOR INDIVIDUALS RESIDING IN HIGH COST AREAS WITH FAMILY INCOME ABOVE 200 PERCENT OF THE FEDERAL POVERTY LINE.

(a) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) COVERAGE OF INDIVIDUALS RESIDING IN HIGH-COST AREAS.—

''(A) IN GENERAL.—For fiscal years beginning with fiscal year 2008, a State shall receive payments under subsection (a)(1) with respect to child health assistance provided to an individual who resides in a high cost county or metropolitan statistical area (as defined by the Secretary, taking into account the national average cost-of-living) and whose effective family income exceeds 200 percent of the poverty line (as determined under the State child health plan), only if such family income does not exceed 200 percent of the poverty line as adjusted for the cost-of-living in the State under subparagraph (B)).

''(B) ADJUSTED POVERTY LINE.—The Secretary shall adjust the poverty line applicable to a family of the size involved with respect to each State to take into account the cost-of-living for each county or metropolitan statistical area in the State, based on the most recent index data from the Council for Community and Economic Research (previously known as the American Chamber of Commerce Research Association),the 2004 Consumer Expenditure Survey of the Bureau of Labor Statistics, and the Bureau of Economic Analysis of the Department of Commerce.''.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''or subsection (c)(8)'' after ''subparagraph (B)''.

(c) REGULATIONS.—Not later than 90 days after the date of enactment of this subparagraph, the Secretary shall promulgate interim final regulations to carry out the amendments made by subsections (a) and (b).

SA 2621. Mrs. LINCOLN (for herself, Ms. SNOWE, Mr. NELSON of Nebraska, Mr. BAUCUS, Mr. GRASSLEY, Mr. KENNEDY, Mr. ENZI, Mr. DURBIN, Mr. CRAPO, and Mr. SMITH) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. SENSE OF SENATE REGARDING ACCESS TO AFFORDABLE AND MEANINGFUL HEALTH INSURANCE COVERAGE.

(a) FINDINGS.—The Senate finds the following:

(1) There are approximately 45 million Americans currently without health insurance.

(2) More than half of uninsured workers are employed by businesses with less than 25 employees or are self-employed.

(3) Health insurance premiums continue to rise at more than twice the rate of inflation for all consumer goods.

(4) Individuals in the small group and individual health insurance markets usually pay more for similar coverage than those in the large group market.

(5) The rapid growth in health insurance costs over the last few years has forced many employers, particularly small employers, to increase deductibles and co-pays or to drop coverage completely.

(b) SENSE OF THE SENATE.—The Senate—

(1) recognizes the necessity to improve affordability and access to health insurance for all Americans;

(2) acknowledges the value of building upon the existing private health insurance market; and

(3) affirms its intent to enact legislation this year that, with appropriate protection for consumers, improves access to affordable and meaningful health insurance coverage for employees of small businesses and individuals by—

(A) facilitating pooling mechanisms, including pooling across State lines, and

(B) providing assistance to small businesses and individuals, including financial assistance and tax incentives, for the purchase of private insurance coverage.

SA 2622. Mr. CASEY (for Mr. ENZI (for himself and Ms. MIKULSKI)) proposed an amendment to the bill S. 845, to direct the Secretary of Health and Human Services to expand and intensify programs with respect to research and related activities concerning elder falls; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Safety of Seniors Act of 2007''.

SEC. 2. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

Part J of title III of the Public Health Service Act (42 U.S.C. 280b et seq.) is amended—

(1) by redesignating section 393B (as added by section 1401 of Public Law 106–386) as section 393C and transferring such section so that it appears after section 393B (as added by section 1301 of Public Law 106–310); and

(2) by inserting after section 393C (as redesignated by paragraph (1)) the following:

''SEC. 393D. PREVENTION OF FALLS AMONG OLDER ADULTS.

''(a) PUBLIC EDUCATION.—The Secretary may—

''(1) oversee and support a national education campaign to be carried out by a nonprofit organization with experience in designing and implementing national injury prevention programs, that is directed principally to older adults, their families, and health care providers, and that focuses on reducing falls among older adults and preventing repeat falls; and

''(2) award grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, for the purpose of organizing State-level coalitions of appropriate State and local agencies, safety, health, senior citizen, and other organizations to design and carry out local education campaigns, focusing on reducing falls among older adults and preventing repeat falls.

''(b) RESEARCH.—

''(1) IN GENERAL.—The Secretary may—

''(A) conduct and support research to—

''(i) improve the identification of older adults who have a high risk of falling;

''(ii) improve data collection and analysis to identify fall risk and protective factors;

''(iii) design, implement, and evaluate the most effective fall prevention interventions;

''(iv) improve strategies that are proven to be effective in reducing falls by tailoring these strategies to specific populations of older adults;

''(v) conduct research in order to maximize the dissemination of proven, effective fall prevention interventions;

''(vi) intensify proven interventions to prevent falls among older adults;

''(vii) improve the diagnosis, treatment, and rehabilitation of elderly fall victims and older adults at high risk for falls; and

''(viii) assess the risk of falls occurring in various settings;

''(B) conduct research concerning barriers to the adoption of proven interventions with respect to the prevention of falls among older adults;

''(C) conduct research to develop, implement, and evaluate the most effective approaches to reducing falls among high-risk older adults living in communities and long-term care and assisted living facilities; and

''(D) evaluate the effectiveness of community programs designed to prevent falls among older adults.

''(2) EDUCATIONAL SUPPORT.—The Secretary, either directly or through awarding grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, may provide professional education for physicians and allied health professionals, and aging service providers in fall prevention, evaluation, and management.

''(c) DEMONSTRATION PROJECTS.—The Secretary may carry out the following:

''(1) Oversee and support demonstration and research projects to be carried out by qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, in the following areas:

''(A) A multistate demonstration project assessing the utility of targeted fall risk screening and referral programs.

''(B) Programs designed for community-dwelling older adults that utilize multicomponent fall intervention approaches, including physical activity, medication assessment and reduction when possible, vision enhancement, and home modification strategies.

''(C) Programs that are targeted to new fall victims who are at a high risk for second falls and which are designed to maximize independence and quality of life for older adults, particularly those older adults with functional limitations.

''(D) Private sector and public-private partnerships to develop technologies to prevent falls among older adults and prevent or reduce injuries if falls occur.

''(2)(A) Award grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, to design, implement, and evaluate fall prevention programs using proven intervention strategies in residential and institutional settings.

''(B) Award 1 or more grants, contracts, or cooperative agreements to 1 or more qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, in order to carry out a multistate demonstration project to implement and evaluate fall prevention programs using proven intervention strategies designed for single and multifamily residential settings with high concentrations of older adults, including—

''(i) identifying high-risk populations;

''(ii) evaluating residential facilities;

''(iii) conducting screening to identify high-risk individuals;

''(iv) providing fall assessment and risk reduction interventions and counseling;

''(v) coordinating services with health care and social service providers; and

''(vi) coordinating post-fall treatment and rehabilitation.

''(3) Award 1 or more grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, to conduct evaluations of the effectiveness of the demonstration projects described in this subsection.

''(d) PRIORITY.—In awarding grants, contracts, or cooperative agreements under this section, the Secretary may give priority to entities that explore the use of cost-sharing with respect to activities funded under the grant, contract, or agreement to ensure the institutional commitment of the recipients of such assistance to the projects funded under the grant, contract, or agreement. Such non-Federal cost sharing contributions may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(e) STUDY OF EFFECTS OF FALLS ON HEALTH CARE COSTS.—

''(1) IN GENERAL.—The Secretary may conduct a review of the effects of falls on health care costs, the potential for reducing falls, and the most effective strategies for reducing health care costs associated with falls.

''(2) REPORT.—If the Secretary conducts the review under paragraph (1), the Secretary shall, not later than 36 months after the date of enactment of the Safety of Seniors Act of 2007, submit to Congress a report describing the findings of the Secretary in conducting such review.''.

SA 2623. Mr. SALAZAR submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. DEMONSTRATION PROJECT TO PROVIDE NURSE HOME VISITATION SERVICES UNDER MEDICAID AND CHIP.

(a) FINDINGS AND PURPOSE.—

(1) FINDINGS.—Congress makes the following findings:

(A) Medicaid and CHIP have collectively provided health insurance coverage to over 38,000,000 low-income pregnant women and children.

(B) Evidence-based home visitation programs can improve the health status of low-income pregnant women and children enrolled in Medicaid and CHIP by promoting access to prenatal and well-baby care, reducing pre-term births, reducing high-risk pregnancies, increasing time intervals between first and subsequent births, and improving child cognitive, social, and behavioral skills, and development.

(C) In addition to health benefits, evidence-based home visitation programs have been proven to increase maternal employment and economic self-sufficiency and significantly reduce child abuse and neglect, child arrests, maternal arrests, and involvement in the criminal justice system.

(D) Evidence-based nurse home visitation programs are cost effective, yielding a 5-to-1 return on investment for every dollar spent on services, and producing a net benefit to society of $34,000 per high risk family served.

(2) PURPOSE.—The purpose of this section is to establish a demonstration project to evaluate the cost-effectiveness and impact on the health and well-being of low-income pregnant mothers and children of providing evidence-based home visitation services for low-income pregnant mothers and children under Medicaid and CHIP, particularly with respect to the impact of such services on—

(A) improving the prenatal health of children;

(B) improving pregnancy outcomes;

(C) improving child health and development;

(D) improving child development and mental health related to elementary school readiness;

(E) improving family stability and economic self-sufficiency;

(F) reducing the incidence of child abuse and neglect; and

(G) increasing birth intervals between pregnancies.

(b) REQUIREMENT TO CONDUCT DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration project under which a State may apply under section 1115 of the Social Security Act (42 U.S.C. 1315) to provide, in accordance with the provisions of this section, medical assistance under the State plan under title XIX of the Social Security Act, child health assistance under the State child health plan under title XXI of such Act, or both for evidence-based home visitation services to children and pregnant women who are eligible for such assistance under such plans.

(2) LIMITATION ON NUMBER OF APPROVED APPLICATIONS.—The Secretary shall only approve as many State applications to provide medical assistance or child health assistance in accordance with this section as will not exceed the limitation on aggregate payments under subsection (d)(2)(A).

(3) AUTHORITY TO WAIVE RESTRICTIONS ON PAYMENTS TO TERRITORIES.—The Secretary shall waive the limitations on payment under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) in the case of a State that is subject to such limitations and submits an approved application to provide medical assistance, child health assistance, or both in accordance with this section.

(c) LENGTH OF PERIOD FOR PROVISION OF ASSISTANCE.—A State shall not be approved to provide medical assistance or child health assistance for evidence-based home visitation services in accordance with the demonstration project established under this section for a period of more than 5 consecutive years.

(d) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $25,000,000 for the period of fiscal years 2008 through 2012.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) LIMITATION ON PAYMENTS.—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $25,000,000; or

(B) payments be provided by the Secretary under this section after September 30, 2012.

(3) FUNDS ALLOCATED TO STATES.—The Secretary shall allocate funds to States with approved applications under this section based on their applications and the availability of funds.

(4) PAYMENTS TO STATES.—The Secretary shall pay to each State, from its allocation under paragraph (3), an amount each quarter equal to the Federal medical assistance percentage, as defined with respect to the State in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), or the enhanced FMAP, as defined with respect to the State in section 2105(b) of such Act (42 U.S.C. 1397ee(b)) (as applicable) of expenditures in the quarter for medical assistance or child health assistance for evidence-based home visitation services provided to low-income pregnant mothers and children who are eligible for such assistance under a State plan under title XIX or XXI of such Act in accordance with the demonstration project established under this section.

(e) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration project established under this section. Such evaluation shall include an analysis of the cost-effectiveness of the project with differentiation between the different types of home health programs and the impact of the programs on Medicaid and CHIP. For purposes of conducting such evaluation, the Secretary shall require a State that submits an application to participate in the demonstration project established under this section to agree, as a condition of approval of such application, to maintain data related to, and be subject to, periodic evaluations based on performance outcomes regarding the following:

(A) Substance abuse during pregnancy.

(B) Prematurity.

(C) Immunizations.

(D) Developmental delay.

(E) Language development.

(F) Emergency room visits and hospitalizations for injury.

(G) Interval between pregnancies.

(H) Workforce participation.

(I) Government assistance use.

(2) REPORT TO CONGRESS.—Not later than December 31, 2012, the Secretary shall submit a report to Congress on the results of the evaluation of the demonstration project established under this section.

(f) DEFINITION.—In this section, the term ''evidence-based home visitation services'' means services (such as services related to improving prenatal health, pregnancy outcomes, child health and development, school readiness, family stability and economic self-sufficiency, reducing child abuse, neglect, and injury, reducing maternal and child involvement in the criminal justice system, and increasing birth intervals between pregnancies) on behalf of a targeted low-income child who has not attained age 2 and is born to a first-time pregnant mother, but only if such services are provided in accordance with outcome standards that have been replicated in multiple, rigorous, randomized clinical trials in multiple sites, with outcomes that improve prenatal health of children, pregnancy outcomes, child health and development, child development, and mental health related to elementary school readiness, reduce child abuse, neglect, and injury, increase birth intervals between pregnancies, and improve maternal employment.

(g) RULE OF CONSTRUCTION.—Nothing in the demonstration project established under this section shall be construed as affecting the ability of a State under Medicaid or CHIP to provide home visitation services as part of medical assistance, child health assistance, or an administrative expense, for which any State received payment under section 1903(a) or 2105(a) of the Social Security Act (42 U.S.C. 1396b(a), 1397ee(a)) for the provision of such services before, on, or after the date of enactment of this Act.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mrs. BOXER. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on August 1, 2007, at 9:30 a.m., to mark up S. 1677, the Currency Reform and Financial Markets Access Act of 2007; S. 1518, the Community Partnership to End Homelessness Act of 2007; an original bill entitled the FHA Modernization Act of 2007; an original bill entitled the Housing Assistance Authorization Act of 2007; an original bill entitled the Private Student Loan Transparency and Improvement Act of 2007; and an original bill entitled the Commission on National Catastrophe Risk Management and Insurance Act of 2007.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mrs. BOXER. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to hold a hearing during the session of the Senate on Wednesday, August 1, 2007, at 2:30 p.m., in room 253 of the Russell Senate Office Building.

The U.S. Department of Commerce and its component bureaus are responsible for the stewardship, protection, and scientific understanding of our ocean environment and its resources, effective use and growth of the Nation's technological resources, and promoting U.S. trade and tourism. The oversight hearing will examine the Department's effectiveness in implementing these goals.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mrs. BOXER. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to hold a hearing during the session of the Senate on Wednesday, August 1, 2007, at 9:30 a.m. in room SD–366 of the Dirksen Senate Office Building.

The purpose of this hearing is to receive testimony on recent advances in clean coal technology, including the prospects for deploying these technologies at a commercial scale in the near future.

The PRESIDING OFFICER. Without objection, it is so ordered.